

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-6

12278

CERTIFICATE OF DEATH

Reg. Dist. No. 2420

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 years.

Hospital, institution, or street address where death occurred:

1004-64 Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

City or town

Cedar Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1004-64 Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

William Joshua Abrams (Abrams)

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Colored Married

6.(b) Name of husband or wife

Sadie Abrams.

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo. day, yr.) April 12 1902

8. AGE: Years 44 Months Days If less than one day hrs. min.

9. Birthplace Prince Georges Co. Md. (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Coal and Lumber yard

12. Name Daniel Abrams

13. Birthplace Prince Georges Co. Md.

14. Maiden name Hattie Abrams

15. Birthplace Prince Georges Co. Md.

16. Informant Agnes Abrams

Address 6411 Jay St. - Cedar Heights, Md.

17. Burial Date thereof. Dec. 26, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Moses Cemetery

Location Anne Arundel Co., Md.

18. Funeral director Henry Washington & Sons

Address 467 N. St. N.W. Wash., D.C.

19. 12/24/46 1946 Carrie F. Campbell

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1946 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1, 1946 to Dec. 22, 1946

and that I last saw him alive on Dec. 22, 1946

Immediate cause of death

Acute Tons

Myocarditis 3 days

Due to

Influenza 3 weeks

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Bellon, M.D.

M. D. or other

Address 6423 Hunt Pl. N.E.

Signed 12-22-46

RECEIVED

DEC 28 1946

BUREAU

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

12279

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

Prince Georges
County

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 5 days.

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 5 days

3. (a) FULL NAME

ELLEN M. BAILEY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife: Rudolph Bailey

7. Birth date of deceased (mo., day, yr.)

September 9, 1883

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace:

Washington, D. C.

(Town, county, and state)

10. Usual occupation:

Housewife

11. Industry or business

12. Name: Jeremiah Fahey

13. Birthplace: County Claire, Ireland

MOTHER FATHER

14. Maiden name: Bridget McNamara

15. Birthplace: County Claire, Ireland

16. Informant: Deceased

Address

17. Removal
(Burial, cremation, or removal. Which?)Date thereof: Dec 28 1946
(month) (day) (year)

Cemetery or crematory

Location: To Washington, D.C.

18. Funeral director: Thomas P. Haulon

Address: 641 3d St. N.E.

19. Date rec'd by registrar: Dec 28, 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

D. C. State

County

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6313 16th St., N. W.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 28th 1946

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov. 22 1946 to Dec 28th 1946 and that I last saw her alive on Dec 28th 1946.

Immediate cause of death:

Pulmonary Tuberculosis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

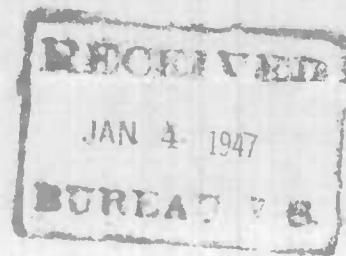
Means of injury

Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.

M. D. or other

Address: Glenn Dale Md. Date signed: 12/28/46



2-25-

2-2430 ————— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15720

12280

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince George
City or town Sandown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 monthsHospital, institution, or street address where death occurred: 12 Ardmore RoadHow long in hospital or institution? 5 months

3. (a) FULL NAME

CAROL BAKER4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Infant

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1945 6. (c) If alive, give age years8. AGE: Years 11 Months Days If less than one day hrs. min.9. Birthplace Washington, D.C. (Town, county, and state)10. Usual occupation none

11. Industry or business

MOTHER FATHER Robert C. Baker

13. Birthplace

14. Maiden name Marian Planck

15. Birthplace

16. Informant Marian PlanckAddress Walter Reed General Hosp.
17. Burial Burial Date thereof 12-2-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ab. nat. CemeteryLocation Ro. 100, Virginia18. Funeral director Mr. W. ChambersAddress Residence, Maryland19. 12/2 1946 Amanda Dauney
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Sandown (If outside city or town limits, write RURAL and give nearest town)Street No. 12 Ardmore Road (If rural, give LOCATION)2.(a) If veteran, name war none

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946 at 10p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 26 1946 to Dec 1 1946
and that I last saw her alive on Nov 30 1946

Immediate cause of death

Hydrocephalus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Moane of injury

Injured at work?

23. SIGNATURE John J. Maloney

M. D. or other

Address Cheverly, Maryland Date signed 12-2-46

RECEIVED

DEC 4 1946

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1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12281

CERTIFICATE OF DEATH

Reg. Dist. No. 243-1

1. PLACE OF DEATH:
County..... Prince Georges
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 1 year, 18 days
Hospital, Institution, or street address where death occurred:
..... Glenn Dale Sanatorium
How long in hospital or institution?..... 1 year, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1621 Q. St. S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
CAROLYN B. BASS
3. (b) Social Security Number
577-10-5509

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced
female white married

6.(b) Name of husband or wife..... Ray Bass

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... 36 years
July 4, 1918

8. AGE: Years..... 28 Months..... 28 Days..... 5 If less than one day
..... hrs. min.

9. Birthplace..... Charles Co., Maryland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

MOTHER FATHER
12. Name..... Thomas Theodore Sinclair
13. Birthplace..... Charles Co., Maryland

MOTHER
14. Maiden name..... Maude Oliver
15. Birthplace..... Charles Co., Maryland

16. Informant..... Deceased

Address

17. Removal to..... Date thereof..... Dec. 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location..... Washington, D.C.

18. Funeral director..... J. William Lee's Sons Co.

Address..... 300-4 St NE Washington, D.C.

19. Date rec'd by registrar..... Dec. 9, 1946

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Dec. 9, 1946, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 21, 1946, to Dec. 9, 1946,
and that I last saw her alive on Dec. 9, 1946.

Immediate cause of death..... Pulmonary Tuberculosis
DURATION..... 16 mo.

Due to..... Tuberculous Laryngitis
DURATION..... 1 year

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

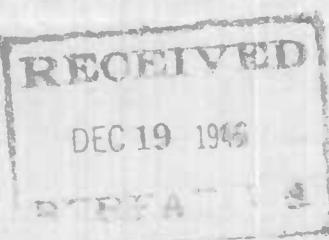
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Pinecone, M.D.

M. D. or other

Address..... Glenn Dale, Md. Date signed..... Dec. 9, 1946



2-2430 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12282

2431

Reg. Diat. No.

1. PLACE OF DEATH:
 County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months, 28 days
 Hospital, Institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 8 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State D. C. County Washington
 City or town (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1532 9th St., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME JERRY BATTLE
 4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Ruth Battle
 7. Birth date of deceased (mo., day, yr.) Jan. 23, 1916
 6.(c) If alive, give age 27 years
 8. AGE: Years Months Days If less than one day
 30 30 10 9 hrs. min.
 9. Birthplace Rocky Mount, North Carolina
 (Town, county, and state)
 10. Usual occupation Truck Driver
 11. Industry or business
 12. Name Louis Battle
 13. Birthplace Rocky Mount, North Carolina
 14. Maiden name Annie Boddie
 15. Birthplace Rocky Mount, North Carolina
 Deceased
 16. Informant
 Address
 17. Removal Date thereof Dec 2 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Washington D.C.
 Location
 18. Funeral director W. Ernest Davis Co
 Address 1432 - 7th St. NW
 19. Dec. 2 1946 Rowland & Phillips
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number
 579-20-5683

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 2 1946 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR. 4, 1946, to DEC 2 1946, and that I last saw him alive on DEC 2 1946.

Immediate cause of death Pulmonary Tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Daniel Leo Pinucane M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 12/2/46

RECEIVED

DEC 11 1946

BUREAU - 3

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2-24.39

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore ¹²

CERTIFICATE OF DEATH

Reg. Dist. No. 1022431

1. PLACE OF DEATH:
 County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 19 days.
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State D. C. County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4027 Beecher St., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

BEATON, GEORGE

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
Male	White	Widowed		
6. (b) Name of husband or wife <u>Ida M. Beaton</u>				
6. (c) If alive, give age <u>years</u>				
7. Birth date of deceased (mo., day, yr.) <u>May 4, 1866</u>				
8. AGE:	Years	Months	Days	If less than one day
80	80	7	5	hrs. min.
9. Birthplace <u>Washington, D. C.</u> (Town, county, and state)				
10. Usual occupation <u>Government Clerk</u>				
11. Industry or business <u>Customs Officer, Government</u>				
12. Name <u>Faulkner Beaton</u>				
13. Birthplace <u>Scotland</u>				
14. Maiden name <u>Lydia Ungerer</u>				
15. Birthplace <u>Bucks Co., Pennsylvania</u>				
16. Informant <u>Deceased</u>				

Address
 17. Cremation Date thereof 12-10-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory to Washington 2c
 Location
 18. Funeral director James T. Phillips Inc.
 Address 317 Pa and 8 E.
 19. 12-10-46 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1946 at 6:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20 1946 to 12/9 1946 and that I last saw her alive on Dec. 9, 1946

Immediate cause of death pulmonary tuberculosis

Duration 5 mrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results Bilateral pulmonary tuberculosis with
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Daniel H. Finegan MD
 M. D. or other
 Address Glenn Dale, Md. Date signed 12/9/46

RECEIVED

DEC 19 1946

BUREAU 78

2-25

2-2430 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

12284

CERTIFICATE OF DEATH

Reg. Dist. No.

2450

1. PLACE OF DEATH:

County

City or town

Pynnes George
Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. W. married

6. (b) Name of husband or wife

Married W. Blandy

7. Birth date of deceased (mo., day, yr.)

Aug 17 1859

6. (c) If alive, give age 88 years

8. AGE:

Years

Months

Days

If less than one day

94

4

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

12. Name

MOTHER FATHER

Wm R Poe

13. Birthplace

Md.

14. Maiden name

Mary

15. Birthplace

Md.

16. Informant

Address

Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Herbert Blandy

3602 Bunker Hill Rd Mt Rainier

Burial

Cemetery or crematory

Location

G. Jacobs Sons

Hyattsville and

Dec 27 1946 James Sevey

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

County

(If outside city or town limits, write RURAL and give nearest town)

3602 Bunker Hill Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
past 2 weeks to Nov 25 - 1946 to Nov 25 - 1946
and that I last saw her alive on Dec 24 1946

Immediate cause of death

Heart failure (Congestive) DURATION 1 day

Due to General exhaustion 1 day

Due to Senility

Other conditions pulmonary congestion
Necrosis of heart

(Include pregnancy within 3 months of death) 40 days

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

M. D. or other

Address Dr. C. D. Blandy Date signed Dec 27 1946

RECEIVED

DEC 28 1946

BUREAU U. S.

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-12

CERTIFICATE OF DEATH

Reg. Dist. No. 12285
26324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9:45-15M

1. PLACE OF DEATH:

County: Prince Georges
City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alice Brown

4. Sex: Female | 5. Color or race: Colored | 6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife: Peter Brown

7. Birth date of deceased (mo., day, yr.): 18 79

8. AGE: 67 Years | Months | Days | If less than one day: .hrs. .min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Farm Home

12. Name: John Brown

13. Birthplace: Maryland

14. Maiden name: Agnes Brown

15. Birthplace: Maryland

16. Informant: Agnes Brown

Address: Woodlawn, Maryland

17. Burial: Date thereof: Dec 28 46
(Burial, cremation, or removal (which?))

(month) (day) (year)

Cemetery or crematory: St. Johns

Location: Clinton, Md.

18. Funeral director: J. B. Johnson

Address: Indianapolis

19. Date rec'd by registrar: Dec 27 46
(Date rec'd by registrar) A. 19

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1946 st 4⁰⁰ AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. . to .19. .

and that I last saw h. . alive on .19. .

Immediate cause of death:

Acute congestive
heart failure
Due to: Cardiomyocleral renal
disease

DURATION

Due to: .

Other conditions: .

(Include pregnancy within 3 months of death)

Major findings or operations: .

Date of op.: .

Ante mortem results: .

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: . Date of: .

Where did injury occur? . (City or town) (County) (State)

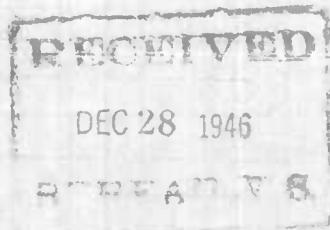
Injured at home, farm, industry, public place (where?)

Means of injury: . Injured at work? .

23. SIGNATURE: J. B. Johnson D. O. M.

Address: Freshwater Date signed: 2-23-46

(Date signed) 2-23-46



1-25-

2-2320 ————— 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Date. No.

1228245

1. PLACE OF DEATH

County

Baltimore Co.

City or town

Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louise Fuller Carr

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

G. Hodges Carr

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 12, 1871

8. AGE:

Years
75

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Louise H. Fuller

FATHER

12. Name

Washington D.C.

13. Birthplace

Josephine Peter

MOTHER

14. Maiden name

Washington D.C.

15. Birthplace

G. Hodges Carr

16. Informant

Hyattsville Md.

Address

Burial

Date thereof

(month) (day) (year)

(Burial, exhumation, or removal. Which?)

Cemetery or crematory

St. James

Location

Tracy's Landing Md.

18. Funeral director

L. Giesche sons

Address

Hyattsville Md.

19. Date

Dec 23, 1946

(Date rec'd by registrar)

Mrs. Jas. Severe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore Co.

City or town

Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No

4107 Hamilton St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 22, 1946, at 3 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2. 28 1946, to 12.22 1946

and that I last saw her alive on

12.21 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 days

Due to Hypertension and

vascular disease

2 years

Due to

Other conditions Right lung emphysema

Hemorrhage

(Include pregnancy within 3 months of death)

5 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

L. B. Rains, M.D.

M. D. or other

West. Rains, Md. Date signed 12.23.46

Address

RECEIVED

DEC 24 1966

REF ID: A3

1-25

2-2450

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12287

CERTIFICATE OF DEATH

Reg. Dist. No. 2390

1. PLACE OF DEATH:

County... PRINCE GEORGE'S
City or town... LAUREL - MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

115 9th Street

How long in hospital or institution?

3. (a) FULL NAME

Henry Bellamy

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... PRINCE GEORGE'S

City or town... LAUREL

(If outside city or town limits, write RURAL and give nearest town)

Street No... 115 9th St.

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

CHANAY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace... LAUREL, PR. GEORGE'S - MARYLAND
(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name... Henry Bellamy

13. Birthplace... Laurel, MD

14. Maiden name... Anna May Brown

15. Birthplace... Laurel, MD

16. Informant... Anna May Chaney

Address

17. Burial

(Burial, cremation, or removal, Which?) Date thereof... Aug. 29, 1946

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1946 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12/26 1946 to 12/28 1946

and that I last saw him alive on December 26, 1946

Immediate cause of death... Bronchopneumonia

DURATION

2 days

Due to... Narcanic agitis, acute
catalase

Due to...

Other conditions... Bronchial asthma

3 months

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Stephens, M.D.

M. D. or other

Address... 305 PR. GEORGE ST.

Date signed... 12/28/46

RECEIVED

JAN 3 1947

BUREAU

T-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

12288

FILE No. I 08 DEC 26 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County.....

Bladensburg

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Beale C. Christopher

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Margrif

6. (b) Name of husband or wife

Odell Christopher

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 14 1899

8. AGE:

Years *47*

Months *1*

Days *2*

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Brigadier - Civil

D.C. Govt

11. Industry or business

Brigadier - Civil

12. Name

John W. Christopher

13. Birthplace

Brigadier - Civil

14. Maiden name

Margaret Dunaway

15. Birthplace

Brigadier - Civil

16. Informant

John Odell Christopher

Address

3601 - Eastern Ave

17. Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Teburon Cemetery

Location

Bladensburg Co. Md.

18. Funeral director

J. W. Lee's Sons Co.

Address

300-428 N.E. Ward St.

19. Date rec'd by registrar

12/16 46

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

MD Rainier

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3601 Eastern Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

12-16-46

19

at 1015 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 10 46 to *12-16-46*

and that I last saw him alive on *12-16-46*

Immediate cause of death.....

acute vascular failure

DURATION

5 hours

Due to..... *Post operation - Gastric*

resection for ulcer

6 months

Due to..... *malignant changes*

Other conditions..... *starvation*

6 months

(Include pregnancy within 3 months of death)

Major findings or operations

ulcer of stomach - post

gall & dilation of stomach

Date of op. *12-16-46*

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. J. Smith

M. D. or other

Address *1433 Monroe St.* Date signed *12/16/46*

RECEIVED

DEC 20 1946

BUREAU

1-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

12280

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

Prince Georges
County.....
Glenn Dale, Maryland
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 6 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 4 mos., 6 days

3. (a) FULL NAME

COBLE, LEVI

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Separated

6.(b) Name of husband or wife Bueford Coble

7. Birth date of deceased (mo., day, yr.) October 7, 1890 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
56 56 2 13 hrs. min.9. Birthplace Roanna County, North Carolina
(Town, county, and state)

10. Usual occupation Bus Boy

11. Industry or business Hot Shoppe

FATHER 12. Name Levi Coble

13. Birthplace Roanna Co., North Carolina

MOTHER 14. Maiden name Emma Warfield

15. Birthplace Roanna Co., North Carolina

16. Informant Deceased

Address

17. Burial, cremation, or removal, Which? Date thereof Dec. 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director Malvern & Schley Inc.

Address 424 - R St N W

19. Date rec'd by registrar Dec. 21 1946 Rowland & Phillips
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County.....

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 929 O. Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

358-07-0473

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1946 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. in alive on 12/20 1946

Immediate cause of death pulmonary tuberculosis

DURATION 5 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 12/20/46



2-2430- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 512

CERTIFICATE OF DEATH

12290 2451

Reg. Dist. No.

1. PLACE OF DEATH

Prince George
Cottage City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Albert Cole

4. Sex

Male

white

5. Color or race

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Annie Gary Cole

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr)

March - 15 - 1875

8. AGE:

Years 71 Months 9 Days 15 If less than one day hrs. mln.

9. Birthplace

Montgomery Co., Md.

(Town, County, and state)

10. Usual occupation

fireman and other

11. Industry or business

Egleman Yeast Company

12. Name

Ezra Cole

13. Birthplace

New York State

14. Maiden name

Martha Mahoney

15. Birthplace

Fayette Co., Pa.

16. Informant

Catherine Virginia Weaver

Address

3802 - 37th Ave., Cottage City, Md.

17. Burial

(Burial, cremation, or removal: Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Monocacy Cemetery

Location

Beallsville, Maryland

18. Funeral director

L. Lassie Long

Address

Hyattsville, Md.

19. Date rec'd by registrar

Jan. 2 1947

(Date rec'd by registrar)

Name of registrar

Nancy S. [illegible]

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Prince George

City or town

Cottage City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3802 - 37th Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec - 30

1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1939 to 2000-30-1946

and that I last saw him alive on Dec - 29

1946

Immediate cause of death

Infection

DURATION

5 mo

Due to: carcinoma of testis of testis May - 1946

Due to: gastric ulcer - gastritis 1939

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

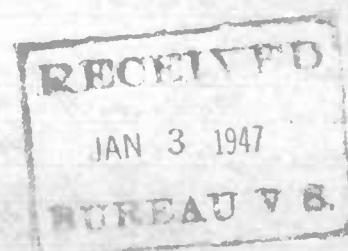
Means of injury Injured at work?

23. SIGNATURE

William C. Miller M.D. or other

Gaithersburg, Md. Date signed

for undertaker



2-245-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1229
Reg. Dist. No. 2391

1. PLACE OF DEATH:
County *Prince George's*
City or town *Laurel*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 mo.*Hospital, Institution, or street address where death occurred: *408 Montgomery St*

How long in hospital or institution?

3. (a) FULL NAME

Susan Elizabeth Bruce Linder

4. Sex <i>Female</i>	5. Color or race <i>White</i>	6. (a) Single, married, widowed, or divorced <i>Widowed</i>
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6. (b) Name of husband or wife: *Robert Lanning Linder*7. Birth date of deceased (mo., day, yr.) *April 18, 1859*6. (c) If alive, give age *years*

8. AGE: Years <i>87</i>	Months <i>7</i>	Days <i>2</i>	If less than one day hrs. <i></i>	min. <i></i>
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8. Birthplace *Crawford Co. Indiana*

(Town, county, and state)

10. Usual occupation: *Housewife*11. Industry or business *Own home*12. Name *Wilford Bruce*13. Birthplace *Crawford Co. Indiana*14. Maiden name *Sarah McMichael*15. Birthplace *Crawford Co. Indiana*16. Informant *Mr. Bentz Wilson Bruce*Address *408 Montgomery St Laurel Md.*17. Burial Date thereof *Dec. 23 '46*(Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *Cave Hill Cemetery*Location *Louisville Kentucky*18. Funeral director *Lloyd Kaiser Inc.*Address *381 Main St. Laurel*19. (2-21) 1946 Date rec'd by registrar *Dec. 23*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State *Maryland* County *Prince George's*City or town *Laurel*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *408 Montgomery St*

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH *December 20 1946* at *8:00 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *December 20 1946* to *Dec 20 1946*and that I last saw her alive on *Dec 20 1946*Immediate cause of death: *acute myocarditis*

DURATION

1 day

Due to: _____

Due to: _____

Other conditions *Brachitis*

1 mo

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

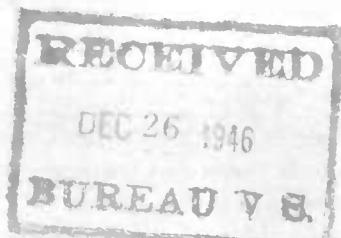
Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Robert D. L. Linder* D. or otherAddress *408 Main St Laurel Md.* Date signed *Dec 23 1946*



2-2370 ————— 1-10

RECEIVED

DEC 21 1946

P. T. READING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12293

CERTIFICATE OF DEATH

12293

Reg. Dist. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

1. PLACE OF DEATH:
 County Baltimore George
 City or town Glen Dale If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
Glen Dale Sanatorium
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Glen Dale If outside city or town limits, write RURAL and give nearest town)
 Street No. Glen Dale Sanatorium If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME Jennie M Douglas
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Wedowed
 6. (b) Name of husband or wife Charles Douglas
 7. Birth date of deceased (mo., day, yr.) February 14, 1893 6. (c) If alive, give age years

8. AGE: Years 53 Months 9 Days 27 If less than one day
 hrs. min.

9. Birthplace Machias Port, Maine (Town, county, and state)

10. Usual occupation Hospital attendant

11. Industry or business Glen Dale Sanitar

12. Name William Dabbin

13. Birthplace Maine

14. Maiden name Laura Thompson

15. Birthplace Point of Maine, Maine

16. Informant daughter, Jeanette Douglas

Address 3145 Mt. Pleasant St. N. W. D.C.

17. Removal Dec 12 1946 Date thereof Dec 12 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bucks Harbor

Location Maine

18. Funeral director N. W. Chambers Co

Address Washington, D.C.

19. Dec 11, 1946 Rowland & Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 19, fo 19and that I last saw h alive on 19Immediate cause of death Acute congestiveheart failureDue to Cardioscrotumrenal diseaseDue to Other conditions

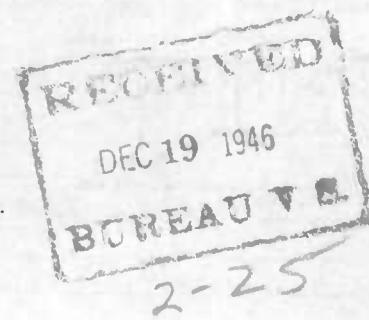
(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work Deputy medical examiner Coroner M. D. Doctor Address Forestville Md Date signed Dec 11, 1946



2-2430 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

12294

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 4 yrs., 9 mos., 20 days.

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 4 yrs., 9 mos., 20 days.

3. (a) FULL NAME

WAYLAND ENGLISH

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

8.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 21, 1875

8. AGE:

Years

Months

Days

If less than one day

71

71

9

5

hrs.

min.

9. Birthplace..... Henderson, Kentucky
(Town, county, and state)

10. Usual occupation..... Solicitor

11. Industry or business..... Photography

12. Name..... Francis M. English

13. Birthplace..... Kentucky

14. Maiden name..... Lollie Anna English

15. Birthplace..... Kentucky

16. Informant..... Deceased

Address

17. Burial.....

(Burial, cremation, or removal, which?)

Date thereof..... Dec. 28 1946
(month) (day) (year)

Cemetery or cemetery..... Columbia Gardens

Location..... Arlington, Virginia

18. Funeral director..... The S.H. Hines Co

Address..... 2901 14th St NW Washington, D. C.

19. Dec. 26, 1946, Rowland S. Phillips
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1101 16th St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... DECEMBER 26 1946 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

MARCH 5 1942 to DEC. 26 1946

and that I last saw him alive on DEC. 26 1946

Immediate cause of death

PULMONARY TUBERCULOSIS

DURATION

Yrs 7 mo

Due to.....

Due to.....

Other conditions..... Complications

G.V. TUBERCULOSIS

(Include pregnancy within 3 months of death)

4 mos.

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

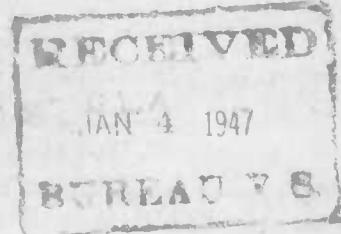
23. SIGNATURE.....

Daniel Leo Pinucane M.D.

M. D. or other

Address..... Glenn Dale, Md.

Date signed..... 12/26/46



2—2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 24

12295

230

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: PRINCE GEORGES'
County.....

City or town..... BERWYN

(If outside city or town limits, write RURAL and give nearest town)

40 YEARS

How long in above place of death?

Hospital, institution, or street address where death occurred:

4713 BERWYN Road

How long in hospital or institution?

3. (a) FULL NAME

ARTHUR OCTAVE ETIENNE

4. Sex

MALE

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

ETIENNE

8.(c) If alive, give age

73

years

7. Birth date of

deceased (mo., day, yr.)

APRIL 24, 1870

8. AGE:

76

Years

Months

Days

If less than one day

— hrs. — min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

ARTHUR OCTAVE ETIENNE.

13. Birthplace

Montreal, Canada

14. Maiden name

OLIVE DORION

15. Birthplace

Montreal, Canada

16. Informant

MARSHA WOLCOTT ETIENNE (wife)

Address

Burial

(Burial, cremation, or removal, Where?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Washington D.C.

18. Funeral director

L. Kascha, Son

Address

Hyattsville, Md.

19. Dec. 15, 1946

(Date rec'd by registrar)

John H. Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County..... Prince Georges'

City or town..... BERWYN, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 4713 BERWYN Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

14 December 1946 at 9 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10. 19. 46.

and that I last saw him alive on 13 December 1946.

Immediate cause of death

CORONARY THROMBOSIS

DURATION $\frac{1}{2}$ hr

Due to Arteriosclerosis 15 yr

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings or operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE *Arthur Octave Etienne M.D.*

M. D. or other

Address *Berwyn, Md.* Date signed *14 DEC 1946*

RECEIVED

DEC 17 1946

BERFAC

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

12296

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH: Pr George
 County: Chesapeake
 City or town: Chesapeake (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 1/2 hrs.
 Hospital, Institution, or street address where death occurred
 How long in hospital or institution? 8 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: D. C. County: D. C.
 City or town: D. C. (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1702 Sales St. N.E. (If rural, give LOCATION)

3. (a) FULL NAME
Raymond Ferber

3. (b) Social Security Number

4. Sex: M 5. Color or race: 6. (a) Single, married, widowed, or divorced:

6. (b) Name of husband or wife: Mary Marie Ferber

7. Birth date of deceased (mo., day, yr.): June 8, 1898 6. (c) If alive, give age: 58 years

8. AGE: 48 Years Months Days If less than one day
 hrs. mln.

9. Birthplace: D. C. (Town, county, and state)

10. Usual occupation: Telephone tester

11. Industry or business

FATHER: 12. Name: John Ferber
 13. Birthplace: D. C.

MOTHER: 14. Maiden name: Ida Gordon
 15. Birthplace: D. C.

16. Informant

Address

17. Burial: Burial Date thereof: 1/2/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Cedar Hill Location: Swiflnd Md.

18. Funeral director: W. Lee Son Co. Address: 300 - 4 - st. N.E.

19. 1/1 19. 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-31-1946 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

12-30-1946 to 12-31-1946 and that I last saw him alive on 12-30-1946

Immediate cause of death: Congestive Heart Disease slurred & colic with diarrhea Rectal Hemorrhage Duration 12 hours

Due to: Antacídicos? P

Due to: Chronic Alcoholism P

Other conditions: Fatty degeneration of liver 9 lbs. (Include pregnancy within 8 months of death)

Major findings or operations: Date of op.

Autopsy results: Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

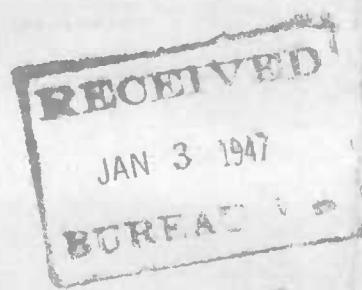
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Bruegger M.D. M. D. or other

Address: Mt. Rainier Md. Date signed: 12-31-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13B

CERTIFICATE OF DEATH

12297

Reg. Dist. No. 285

1. PLACE OF DEATH:
 County Prince George
 City or town Mt. Rainier
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, Institution, or street address where death occurred:
4213-Rainier Ave. Mt. Rainier

How long in hospital or institution?

3. (a) FULL NAME
THOMAS B. FESMIRE.

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Aug. 6th 1900 6. (c) If alive, give age..... years

8. AGE: Years 46 Months Days If less than one day hrs. min.

8. Birthplace Philadelphia Pa.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Ith. M. Fesmire

13. Birthplace Pa.

14. Maiden name Martha V. Lunny

15. Birthplace Pa.

16. Informant Martha V. Lunny

Address 4213-Rainier Ave. Mt. Rainier Md.

17. Burial Date thereof 12/14/1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Va.

18. Funeral director W. J. Kelly

Address 3200-B.P. Ave. Mt. Rainier Md.

Dec 13 1946 James Sevey
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Mt. Rainier (If outside city or town limits, write RURAL and give nearest town)

Street No. 4213-Rainier Ave. (If rural, give LOCATION)

2. (a) If veteran, name war World War II

3. (b) Social Security Number 080-01-1702

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1946 at 8²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 9, 1944 to Dec. 12, 1946

and that I last saw him alive on Dec. 11, 1946

Immediate cause of death Pulmonary Tuberculosis. DURATION 34 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Connor M.D. M. D. or other

Address 2026-16th St. N.W. Date signed 12/12/46.

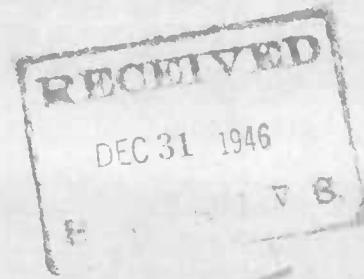
Washington, D.C.

RECEIVED

DEC 17 1946

BUCKLE

1-35



2-25

2-2430-2-10

1. PLACE OF DEATH

County of PRINCE GEORGE'S.

Township of

or Borough of NAYLOR

City of

CERTIFICATE OF DEATH

Registration
District No.61
234COMMONWEALTH OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS12299
File No.

Registered No.

Ward)

[If death occurred in a
Hospital or Institution
give its NAME instead
of street and number.]

2. FULLNAME

MARY ELIZABETH FLEET

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED
OR DIVORCED (write the word)

F COLORED

WIDOWED

5a. If married, widowed, or

(or) WIFE of

ROBERT LANDER FLEET

6. DATE OF BIRTH (month, day, and year)

OCT. 21, 1898

7. AGE

Years
48Months
2Days
4IF LESS than
1 day, hrs.
or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.....(b) General nature of industry,
business, or establishment in
which employed (or employer).
HOUSe WIFE
(REBELL)

(c) Name of employer

9. BIRTHPLACE (city or town)

NOTTINGHAM

(State or country)

PR. GEORGE'S, MD.

10. NAME OF FATHER

Osborne L. F.

11. BIRTHPLACE OF FATHER (city or town)

NOTTINGHAM

(State or country)

D. L. COOK

12. NAME OF MOTHER

Grace Llyson

13. BIRTHPLACE OF MOTHER (city or town)

NOTTINGHAM

(State or country)

P. L. COOK

14.

Informant

MRS. REBECCA LEE

(Address)

NAYLOR, MD

15. Filed

Dec 27, 1946

R. B. Johnson, M.D.

Death

Date

11-3184

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

DECEMBER 25 1946
(Month) (Day) (Year)

17.

I HEREBY CERTIFY, That I attended deceased from,

JUNE, 1946, to, DECEMBER 22, 1946

that I last saw her alive on, DECEMBER 22, 1946
and that death occurred, on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH* was as follows:

CARDIOPRONEAL VASCULAR DISEASE

ESSENTIAL HYPERTENSION

VASCULAR ACCIDENT

(duration) 6 yrs. mes. ds.

CONTRIBUTORY
(SECONDARY)

DIABETES MELLITUS

(duration) yrs. mos. da.

18. Where was disease contracted
If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Alfred P. Labin, M.D.
Dec 25, 1946 (Address) AQUASCO, MD.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL. (See reverse side for additional space.)19. PLACE OF BURIAL, CREMATION OR
REMOVALBurial
Naylor, George

20. UNDERTAKER

J. B. Johnson, Crematory
ADDRESS

Dec. 28 1946

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

Statement of cause of death.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of

the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., carcinoma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicaemia" "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—Probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."*

Space for additional information by physician

DEC 28 1946

BUREAU V 6

2-2320-1-10

1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 2370

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex:

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

1860

8. AGE: Year Months Day If less than one day

86

0

0

hrs.

min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, if any)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

18

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 8th 46, at 11 A.M.

I CERTIFY that death occurred on the date above elated: that I attended deceased from

December 6 1946, to December 8 1946,

and that I last saw her alive on December 8th 1946.

Immediate cause of death

Pulmonary Edema

DURATION

24 hours

Due to: Arteriosclerotic Cardiovascular Disease

Due to:

Other condition: Senility

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Moore of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 12-8-46

RECEIVED

DEC 10 1946

BOSTON

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12301

CERTIFICATE OF DEATH

2450

Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Prince George
City or town: Pineydale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Residence 5602-54th Ave.

How long in hospital or institution? None

3. (a) FULL NAME

Harry Elwood Gray

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married
Helen Shepard Gray

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct 1, 1905

6. (c) If alive, give age 41 years

8. AGE: Years Months Days If less than one day

41 1 15 hrs. min.

9. Birthplace Washington, D.C.

(Town, county, and state)

10. Usual occupation Research Statistician

11. Industry or business Potomac Elec. Power Co

12. Name James S. Gray, Sr

13. Birthplace Laurel, Md.

14. Maiden name Mangle Elwood

15. Birthplace Washington, D.C.

16. Informant James S. Gray, Jr

Address 5602-54 ave Pineydale Md

17. Burial Date thereof Dec 17 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Colma Harbor Md

18. Funeral director S. Jacobs Sons

Address Hyattsville Md

Dec 16 1946 James Seery

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Pineydale, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5602-54th Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1, 1945, to Dec 15, 1946.

and that I last saw h. alive on Dec 14, 1946.

Immediate cause of death: Gray mother, Lateral

Schlerosis

5 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John Schermer

M. D. or other

Address: Hyattsville Md Date signed 1/15/47

RECEIVED

DEC 20 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1570

12302

CERTIFICATE OF DEATH

Reg. Dist. No.

231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County..... Prince George
City or town..... Cheltenham
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 1 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... County.....
City or town..... (If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1946

8. AGE: Years Months Days If less than one day
1 1 hrs. min.9. Birthplace Cheltenham, Prince George, Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... Carl Haas

13. Birthplace Chel.

14. Maiden name..... Emily Upton

15. Birthplace Md.

16. Informant..... Carl Haas

Address 8419 Balti Ave Berwyn Md.

17. Burial Date thereof..... 12/19/46
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Greensboro

Location..... Greensboro Md.

18. Funeral director..... Raymond B. Rawlings

Address..... Greensboro, Md.

19. 12/19 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 18, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

Pulmonary edema

Due to.....

Congenital defect inter. extracardiac

Due to.....

congenital

DURATION

6 hrs.

From birth

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Francis Warren, M.D.

M. D. or other

Address..... 1746-1st St. N.W. Date signed..... 12/19/46

Registrar

RECEIVED

DEC 20 1946

BUREAU OF INVESTIGATION

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *R.D.*

12303

2300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: *Po George*
 County: *Berwyn* Md
 City or town: *Berwyn* Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *14 Months*
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: *Md* County: *Berwyn*
 City or town: *Berwyn* Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *8402* 49th St
 (If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

3. (a) FULL NAME
Laura Ann Hall

4. Sex: *Female* 5. Color or race: *white* 6.(a) Single, married, widowed, or divorced: *Single*

6.(b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.): *1868* 6.(c) If alive, give age: *years*

8. AGE: Years: *78* Months: *9* Days: *28* If less than one day: *hrs.* *min.*

9. Birthplace: _____ (Town, county, and state): *Hazleton Pa*

10. Usual occupation: *Hazleton Pa*

11. Industry or business: *None*

12. Name: *William John Hall*

13. Birthplace: *Pa*

14. Maiden name: *Sarah Merrick*

15. Birthplace: *Pa*

16. Informant: *Mrs Edna N Gover*

Address: *8402 - 49th Berwyn Md.*

17. Burial: *Burial* Date thereof: *Dec 7, 1946*
 (Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory: *El Lincoln*
 Location: *Colmar Manor Md*

18. Funeral director: *L. Etienne, Esq.*

Address: *Colmar Manor Md.*

19. Date rec'd by registrar: *19 Dec 1946* John D. Smith
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: *Dec 4th* 1946 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *act* 1946, to *Dec 2* 1946
 and that I last saw her alive on *Dec 2* 1946Immediate cause of death: *Chronic Endocarditis* DURATION *2 yrs +*Due to: *Arteriosclerosis* DURATION *2 yrs +*

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings or operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

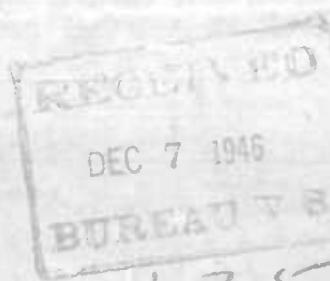
Accident, suicide, or homicide. Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: _____ Injured at work? _____

23. SIGNATURE: *A. O. Etienne* M. D. or other _____Address: *Berwyn, Md.* Date signed: *12/4/46*



1-35

RECEIVED

DEC 23 1946

SEARCHED

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12305

CERTIFICATE OF DEATH

Reg. Dist. No. 142

1. PLACE OF DEATH: *Prince Georges*
 County: *Chapel Oaks*
 City or town: *Chapel Oaks*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *15 months*
 Hospital, Institution, or street address where death occurred: *1202 - 57" Ave.*
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: *Maryland* County: *Prince Georges*
 City or town: *Chapel Oaks*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: *1202* 57" Ave.
 (If rural, give LOCATION)

3. (a) FULL NAME

Thomas Eugene Howard

3. (b) Social Security Number

4. Sex: *Male* 5. Color or race: *Negro* 6. (a) Single, married, widowed, or divorced: *Male Negro*
 7. Birth date of deceased (mo., day, yr.): *Sept. 22, 1945* 8. (c) If alive, give age: *years*
 8. (c) If alive, give age: *years*
 8. (c) If alive, give age: *years*
 9. Birthplace: *Chapel Oaks, Prince Geo. - Md.*
 (Town, county, and state)

10. Usual occupation:
 11. Industry or business:
 12. Name: *Edward Eugene Nelson*
 MOTHER FATHER 13. Birthplace: *Pittsburgh, Pa.*
 14. Maiden name: *Mary Shulma Howard*
 15. Birthplace: *Washington, D.C.*
 16. Informant: *Mrs. Mary J. Howard*
 Address: *1202 - 57" Ave.*

17. Removal: *Removal* Date thereof: *Dec. 27, 46*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: *Washington D.C.*
 Location: *Washington D.C.*
 18. Funeral director: *Arthur L. Hollings*
 Address: *4339 Hunt Pl. N.E.*
 Date rec'd by registrar: *Dec. 27 1946* Carrier: *C. Campbell*

MEDICAL CERTIFICATION

20. DATE OF DEATH: *December 27 1946* at *4:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec. 27 1946* to *Dec. 27 1946* and that I last saw him alive on *Dec. 27 1946*

Immediate cause of death: *Fluid Aspiration*

Due to: *Vomiting*

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

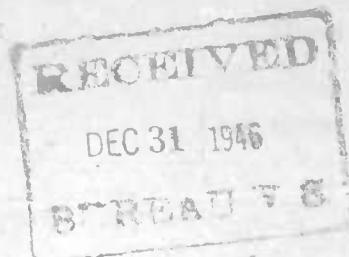
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

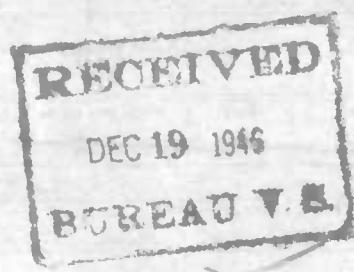
Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: *John W. Hollings, M.D.* M. D. or other
 Address: *1691 Eastern Ave NE* Date signed *12/27/46*



1-35



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

12307

1950

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal; which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Seagoville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 23 1946 at 5:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

19

and that I last saw h alive on

19

Immediate cause of death

Myocardial infarction

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

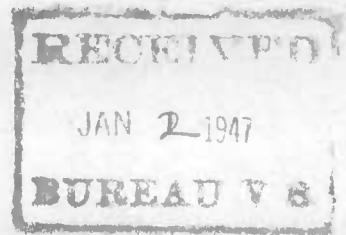
Injured at work?

23. SIGNATURE

M. D. or other

Address At Laurel Md Date signed 12/26/46 231

Registrar



2-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12308

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George County

City or town Near Hyattsville and
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Mother Jones Rest Home

How long in hospital or institution?

3. (a) FULL NAME

LOTTIE HOOVER JACKMAN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6. (b) Name of husband or wife James W. Jackman

7. Birth date of deceased (mo., day, yr.) June 7, 1877

8. AGE:	Years	Months	Days	If less than one day
	69	6	23	hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Retired, Real Estate

11. Industry or business

12. Name	Thomas Zell Hoover
13. Birthplace	Washington, D. C.

14. Maiden name	Alice Hains
15. Birthplace	New York State

16. Informant Mr. Frank Hoover

Address 6807 Glenbrook Rd. Bethesda, Md

17. Burial Date thereof 1/2/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director W. Reuben Humphrey

Address Bethesda, Maryland

19. Date rec'd by registrar 18-47 James Severy

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) None

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 29 1946 to December 29 1946

and that I last saw her alive on Dec 29 1946

Immediate cause of death

Cardiac decompensation
due to mitral regurgitation

Due to

Due to

Other conditions general debility, pallor
chronic bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

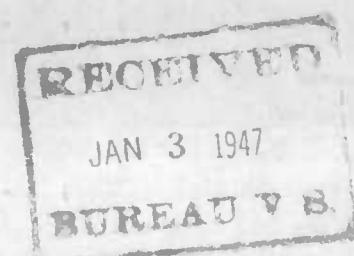
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm A. Shannon, M.D.

Address 113 Carroll St. H. W. Date signed 12-31-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

12309

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH:

County

City or town

Prince Georges

Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 yrs.

Hospital, institution, or street address where death occurred?

Sacred Heart Home

How long in hospital or institution?

2 yrs.

3. (a) FULL NAME

Jameson C. H. Virgin Regna

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

Clarence Jameson

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

March 28 1863

8. AGE:

Years
82

Months

Days

If less than one day

hrs. min.

9. Birthplace

Charles City Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Washington A. Posey

MOTHER FATHER

12. Name

Washington A. Posey

13. Birthplace

Md.

14. Maiden name

Margaretha Hammersley

15. Birthplace

Md.

16. Informant

Hosp. Records

Address

Burial

Date thereof Dec 6, 1946

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

St. Agnes

Location

Bel Air, Md.

18. Funeral director

Hunt & Ryan

Address

Waldorf, Md.

19. Date rec'd by registrar

Dec 4

1946

James Devey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Md.

County

Charles

City or town

Bel Air

County

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

December 4

46

19 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1

46

19 to Dec. 4 1946

and that I last saw her alive on December 3 1946

Immediate cause of death

Arteriosclerotic Heart Disease

Congestive failure

DURATION

9 mos.

4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Thomas J. Collins M.D. M. D. or other

Address 322-H St. NE Date sign DEC 4 1946



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

CERTIFICATE OF DEATH

Reg. Dist. No. 12310 2420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Prince George
City or town Chapel Gates
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred: 5403 Addison Chapel Road

How long in hospital or institution?

3. (a) FULL NAME

4. Sex Male Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Cleopatra Jefferson 6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1890

8. AGE: Years 56 Months 9 Days 21 If less than one day
hrs. min.

8. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business School

12. Name Other Jefferson

13. Birthplace Virginia

14. Maiden name Mary Taylor

15. Birthplace Virginia

16. Informant Cleopatra Jefferson

Address 5403 Addison Chapel Rd Chapel Gates

17. Burial Burial Date thereof 12/4/46
(Burial, cremation, or removal. Which?)

Cemetery or crematory Not known
Location Baltimore Md.

18. Funeral director Henry S Washington & Sons

Address 467 N St N.W.

19. Date rec'd by registrar Dec 1 1946 Registrar Carrie Campbell
(Date rec'd by registrar) Registrar (Signature) M. D. (Mother)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George

City or town Chapel Gates
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5403 Address Addison Chapel Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number 212-16-0287

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death Acute congestive heart failure

Due to Cardiac vascular cerebral disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

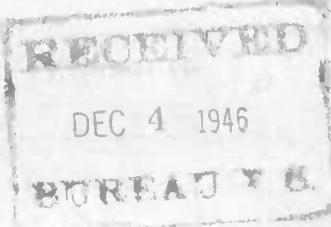
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. S. Jefferson M. D. (Mother)

Address Frostdale Md Date signed Dec 1 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

12311
Reg. Dist. No. 2421

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Baltimore
City or town Allentown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

7112 Allentown Rd

How long in hospital or institution?

3. (a) FULL NAME

Charles Henry Johnson

4. Sex

5. Color or race Black
Colored married

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Eleanor Johnson

7. Birth date of deceased (mo., day, yr.)

Oct 24, 18896.(c) If alive, give age 79 years

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>1</u>	<u>18</u>	hrs. min.

9. Birthplace

Oxon Hill Md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Charles Johnson

12. Name

Charles Johnson

13. Birthplace

Oxon Hill Md

14. Maiden name

Mary Calvert

15. Birthplace

Oxon Hill Md

16. Informant

Charles Johnson

Address

7112 - Allentown Road

17. Burial

Burial Date thereof Dec. 14, 1946

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Oxon Hill - Md

Location

Oxon Hill - Md

18. Funeral director

John H. Hayes & Co.

Address

901 - 3rd St. S.W.

19. 12-12-46

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore BaltimoreCity or town Allentown (If outside city or town limits, write RURAL and give nearest town)Street No. 7112 - Allentown Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 11, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive 00

Immediate cause of death

Acute Congestive heart failure
Due to Arteriosclerotic cerebral disease

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

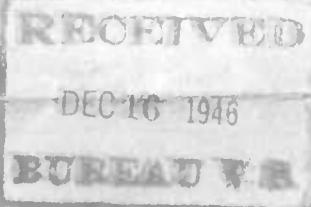
Means of injury..... Injured at work?

Repetitive mechanical trauma

23. SIGNATURE

M. D. or other

Address Forest Hill Date signed 12-11-46



1-25

2-2420 — 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12312

2451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Prince George
 County: Riverdale
 City or town: Riverdale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred: Leeland Memorial Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Md. County: Prince George
 City or town: Greenbelt
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10 North Southway
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME
Johnson, Mrs. Clara Mae

4. Sex: Fem. 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widowed
 6. (b) Name of husband or wife: Leslie Jackson Johnson
 (Deceased) 6. (c) If alive, give age: years

7. Birth date of deceased (mo. day, yr.): Oct. 24, 1881

8. AGE: Years: 65 Months: 1 Days: 22 If less than one day: hrs. min.

9. Birthplace: Kentucky
 (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: William Henry Austin

MOTHER FATHER 12. Name: Kentucky
 13. Birthplace: Clemmie M. Morrison

MOTHER 14. Maiden name: Kentucky

15. Birthplace: Hospital Records

16. Informant: Hospital Records

Address:

17. Burial Date thereof: 12-18-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Old Hickory Cemetery

Location: Lebanon, Ky. Co.

18. Funeral director: WW Chambers

Address: Riverdale - rd

19. Date rec'd by registrar: Dec 18 1946
 (Date rec'd by registrar) Mrs. Jas. Severe
Deputy Clerk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16, 1946 at 9:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 45 to Dec. 16, 1946 and that I last saw her alive on December 16, 1946.

Immediate cause of death: Uremia DURATION

Due to: Hypertensive cardio-penal disease 10 days

Due to: 2 years

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hans Wadz, M.D. M. D. or other

Address: 30-0 Bridge Rd, Greenbelt, Md. Date signed: 12-16-46

RECEIVED

DEC 21 1946

1-25

2-2450-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ¹ No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

12313
Reg. Dist. No. 2430

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Bowie Md

Bro. Geo Co

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jefferson C. Kinney

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

Alice Kinney

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

Nov 28, 1884

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

South Carolina

(Town, county, and state)

10. Usual occupation

Construction worker

11. Industry or business

Graeme Kinney

south carolina

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date thereof (month) (day) (year)

Date of op.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14, 1946, at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on

19.

Immediate cause of death

Hernorrhage at School

DURATION

Due to multiple Cerebral injuries
to external body

Due to

Other conditions

(Include pregnancy within 3 months of death)

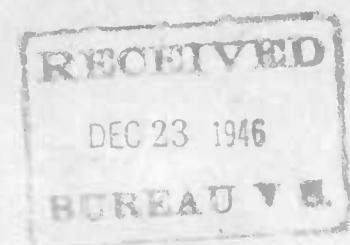
Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-13-46Where did injury occur? Bowie (City or town) (County) (State)Injured at home, farm, industry, public place (where?) at schoolMeans of injury street & stone Injured at work? noDeputy fire department Bladensburg Name John23. SIGNATURE John Kinney M. D. or other John KinneyAddress Holmesville Md Date signed 12-14-46



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

12314

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

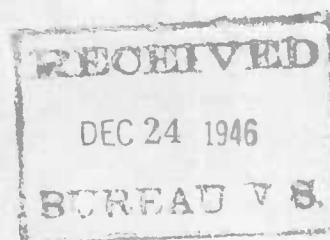
MARGIN RESERVED FOR BINDING

VS A15 9-45-15 M

1. PLACE OF DEATH:		Prince Georges Cheverly, Md.		
County		City or town (If outside city or town limits, write RURAL and give nearest town)		
3 hrs. 55 min				
How long in above place of death?				
Hospital, Institution, or street address where death occurred:		Pr. Geo. General Hosp.		
How long in hospital or institution?		3 hrs. 55 min		
3. (a) FULL NAME				
Knobla, Male infant				
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
m	w	newborn		
6. (b) Name of husband or wife				
7. Birth date of deceased (mo. day, yr.)				
6. (c) If alive, give age years				
8. AGE: Years Months Days If less than one day				
3 hrs. 55 min				
9. Birthplace Pr. Geo. Cheverly, Md (Town, county, and state)				
10. Usual occupation				
11. Industry or business				
FATHER	12. Name Bernard Knobla			
MOTHER	13. Birthplace Wisconsin			
14. Maiden name Marguerite Wagner				
15. Birthplace Wisc. Wisconsin				
16. Informant				
Address				
17. Cremation Date thereof 12/20/46 (Burial, cremation, or removal. When?) (month) (day) (year)				
Cemetery or crematory Prince Georges General Hospital				
Location Cheverly, Md.				
18. Funeral director G. K. Bealy, Jr.				
Address same				
19. 12/23 1946 (Date rec'd by registrar)				

2. USUAL RESIDENCE (HOME) OF DECEASED:	
(For newborn infants give residence of mother)	
Md. Prince Georges	
State County	
Riverdale	
City or town (If outside city or town limits, write RURAL and give nearest town)	
5632 64th Ave.	
Street No. (If rural, give LOCATION)	
2. (a) If veteran, name war	
3. (b) Social Security Number	

MEDICAL CERTIFICATION				
20. DATE OF DEATH 12-19-1946, a.m. 12 MN				
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12-18 1946 to 12-19 1946 and that I last saw h. in alive on 12-18 1946 to 12-19 1946				
Immediate cause of death <u>Tuberculosis - due to Central respiratory depression</u>				
DURATION				
Due to <u>Prematurity</u> <u>2-12"- 30 weeks gestation</u>				
Due to				
Other conditions				
(Include pregnancy within 3 months of death)				
Major findings of operations				
Date of op.				
Autopsy results				
PHYSICIAN: Please underline the cause to which death should be charged statistically.				
22. VIOLENCE: If death was due to external causes, fill in the following:				
Accident, suicide, or homicide Date of				
Where did injury occur? (City or town) (County) (State)				
Injured at home, farm, industry, public place (where?)				
Means of injury Injured at work?				
23. SIGNATURE <u>Frances Warner M.D.</u> M. D. or other				
Address <u>1246 - 1st St. N.W.</u> Date signed <u>10/19/46</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

CERTIFICATE OF DEATH

12315

Reg. Dist. No. 2300

1. PLACE OF DEATH:

County *Prussia Georges*City or town *Murkrusk* (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *Definite*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Mary Anna Lomax*4. Sex *Female* 5. Color or race *Colored* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) *Sept. 6 1921* 8. (c) If alive, give age years8. AGE: Years *25* Months *3* Days *21* 11 less than one day hrs. min.9. Birthplace *Murkrusk* md. (Town, county, and state)

10. Usual occupation:

11. Industry or business

12. Name *William Henry Lomax* 13. Birthplace *md.*14. Maiden name *Mary Jane Brewster* 15. Birthplace *md.*16. Informant *William Henry Lomax* Address *Murkrusk Md.*17. Burial Cemetery or crematory *Queen's Chapel* Date thereof *Dec. 29, 1946* (Burial, cremation, or removal. Which?) (month) (day) (year)Location *Murkrusk Md.*18. Funeral director *Henry S. Washington Sons* Address *467 N. Potowmack Wash. D.C.*19. (Date rec'd by registrar) *Dec. 28th 1946* John Smith Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Prussia Georges*City or town *Murkrusk*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 24 1946*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw her alive on *Dec 22 1946*

Immediate cause of death:

*Dehydration*Due to *Pulmonary TB*

DURATION

*2 mos**5 yrs*

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. S. Hudson, M.D.*

M. D. or other

Address *Laurel, Md.* Date signed *12-24-46*

RECEIVED

DEC 31 1946

REGIMENTAL

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12316
2310
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Prince George
County: Prince George

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 1/2 hours

Hospital, institution, or street address where death occurred: Prince George General Hosp.

How long in hospital or institution? 5 1/2 hrs.

3. (a) FULL NAME Rose A. Long

4. Sex: Female | 5. Color or race: w | 6. (a) Single, married, widowed, or divorced: married

6. (b) Name of husband or wife: Rubin K. Long

7. Birth date of deceased (mo., day, yr.): Dec 1879

8. AGE: Years: 67 | Months: | Days: | If less than one day: hrs: | min: |

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

12. Name: Bill Smith

13. Birthplace: Virginia

14. Maiden name: Jenny Farmer

15. Birthplace: Virginia

16. Informant: Mrs. Helen Roberts

Address: Removal

17. (Burial, cremation, or removal. Which?) Date thereof: Dec 6, 1946
(month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location: Washington, D.C.

18. Funeral director: Robert Smattingly

Address: 131-11th St. S.E. Wash. D.C.

19. (Date rec'd by registrar) 12/6 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)

Street No: 507 | 67th Place
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6, 1946, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , to 19. ,

and that I last saw h. alive on .

Immediate cause of death: Pulmonary edema

Followed by:

Due to: Bilateral bronchopneumonia

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: as above Date of op.:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James D. Smith M. D. or other

Address: 7 Westworld Rd Date signed: 12-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

12317

2450

Reg. Dist. No.

1. PLACE OF DEATH:

County

PRINCE GEORGE'S

City or town

HYATTSVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 yr 3 mos.

Hospital, institution, or street address where death occurred:

SACRED HEART HOME

How long in hospital or institution?

1 yr. 3 mo.

3. (a) FULL NAME

CATHERINE MC CHESNEY

3. (b) Social Security Number

no

4. Sex

Female White Widow

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

CHARLES G.

7. Birth date of

deceased (mo., day, yr.)

May 29, 1862

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day
84 6 7 hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Bentford SAUTER

12. Name

GERMANY

13. Birthplace

CATHERINE BISEN HAVER

14. Maiden name

GERMANY

15. Birthplace

SACRED HEART HOME

16. Informant

HYATTSVILLE, MD

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)
12-9-46

Cemetery or crematory

Rock Creek Cemetery

Location

Washington, D.C.

18. Funeral director

Francis J. Collins

Address

3821-14th St. N.W. Wash. D.C.

Dec 6

1946

Date rec'd by registrar

James Sevey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D. C. County

City or town

WASHINGTON (If outside city or town limits, write RURAL and give nearest town)

Street No.

3426-16TH ST. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1946 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1946 to Dec 5 1946 and that I last saw her alive on Dec 5 1946

Immediate cause of death

Soreness of rectum

Due to

Unknown

Due to

Old age

(Include pregnancy within 8 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Data of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph J. McCarthy MD

3001 1st St. N.W. D.C. Date signed 12/6/46

Address

RECEIVED BY TELETYPE STATE DEPARTMENT
TELETYPE SECTION
RECEIVED BY TELETYPE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

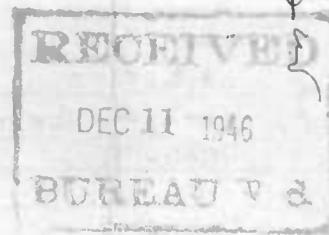
2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

12318-245
e.g. Dist. No.

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?			Brentwood			
Hospital, Institution, or street address where death occurred:			4310-37th. Street			
How long in hospital or institution?			(If rural, give LOCATION)			
3. (a) FULL NAME			3. (b) Social Security Number			
Harland Odell Mc Elwain						
4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced				
Male	White	Married				
6.(b) Name of husband or wife..... Louise T. Robinson						
6.(c) If alive, give age..... years						
7. Birth date of deceased (mo., day, yr.) July 5, 1871						
8. AGE:	Years	Months	Days	If less than one day		
	75			hrs.	min.	
9. Birthplace..... Iowa (Town, county, and state)						
10. Usual occupation..... Repairman						
11. Industry or business..... Jewelry Business						
FATHER	12. Name..... Unknown					DURATION
13. Birthplace..... ?						9 months
MOTHER	14. Maiden name..... Unknown					
15. Birthplace..... ?						
16. Informant..... Louise T. Mc Elwain						(Include pregnancy within 3 months of death)
Address 4310-37th. Street, Brentwood, Md.						Major findings of operations.....
17. Burial..... Date thereof Dec. 11, 1946						Date of op.
(Burial, cremation, or reinterment. Which?) (month) (day) (year)						
Cemetery or crematory..... Rice Cemetery Elkhart, Indiana						Autopsy results.....
Location..... Elkhart, Indiana						PHYSICIAN: Please underline the cause to which death should be charged statistically.
18. Funeral director..... Wm. J. Valley						22. VIOLENCE: If death was due to external causes, fill in the following:
Address 3200-R.I.Ave., Mt. Rainier, Md.						Accident, suicide, or homicide..... Date of.....
19. Date rec'd by registrar) 1946 James Sevey						Where did injury occur?..... (City or town) (County) (State)
						Injured at home, farm, industry, public place (where?)
						Means of injury..... Injured at work?
						23. SIGNATURE.....
						M. D. or other.....
						Address..... Mt. Rainier, Md.
						Date signed 1946

1946
Dr. James T. Boyd, County
Coroner, Notified by means
approva. *[Signature]*



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

12319

CERTIFICATE OF DEATH

Reg. Dlat. No. 2451

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 3 years

3. (a) FULL NAME

Nora M^e Lanney

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

widow

6. (b) Name of husband or wife

Michael J. Mc Lanney

7. Birth date of deceased (mo., day, yr.)

Sept 28, 1859

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

87

hrs.

min.

9. Birthplace

Wash DC

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

Hornsey Connors

12. Name

Ireland

13. Birthplace

14. Maiden name

Ireland

15. Birthplace

Ireland

16. Informant

Dental Records

Address

Sacred Heart Home

17. Burial

Date thereof 12/28/46

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Mt. Olivet

Location

Washington D.C.

18. Funeral director

T. J. Costello

Address

1722 N. Capitol St. N.W.

19. (Date rec'd by registrar)

Dec. 25, 1946

Mrs. Jas. S. Severe

S. S. S.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Wash

DC

County

Washington

DC

(If outside city or town limits, write RURAL and give nearest town)

Street No.

6619

- Westminster NW

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 25, 1946, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 23, 1946, to Dec. 25, 1946

and that I last saw her alive on Dec. 23, 1946

Immediate cause of death

Cardio-vascular - renal disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

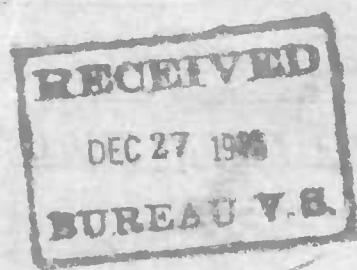
Means of injury Injured at work?

23. SIGNATURE J. A. Connor, M.D.

M. D. or other

Address 3226-16 St. N.W. Date signed 12/25/46

Washington, D.C.



2-2450 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BPO

CERTIFICATE OF DEATH

12320
2340

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince George
City or town: Piscataway, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Georgia Frances Middleton

4. Sex: Female | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife: Mr. Alexander Middleton

7. Birth date of deceased (mo., day, yr.): March 23, 1874

8. AGE: Years: 72 | Months: 9 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Piscataway, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

12. Name: George Underwood

13. Birthplace: Accokeek, Maryland

14. Maiden name: Ann Underwood Boswell

15. Birthplace: Accokeek, Maryland

16. Informant: Alexander Middleton

Address: Piscataway, Md.

17. Burial: Date thereof: Dec 31-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Piscataway, Md.

18. Funeral director: Thomas F. Murray's Funeral

Address: 2007 Nichols Ave. S.E. Home

19. (Date rec'd by registrar): 12/28 | 1946 | Mrs. Elton Davis

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland | County: Prince George Co
City or town: Piscataway, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/26 | 1946 | P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1937 to 12/26 1946

and that I last saw her alive on 12/20 1946

Immediate cause of death:

Oedemus

Compensation

Due to: C. V. D. Disease

Due to: Paroxysm

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of:

Where did injury occur? (City or town) (County) (State)

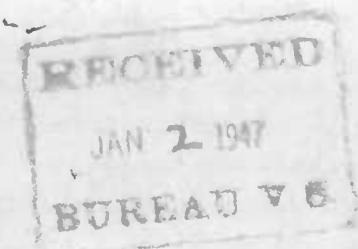
Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

23. SIGNATURE:

D. L. Evans, M.D. | M.D. or other
Address: Evansdale, Md. | Date signed: 12/26/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1321

12321

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
4 years

Hospital, Institution, or street address where death occurred:
Hill Road

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

male white Widowed

8. (b) Name of husband or wife..... James Miles

7. Birth date of deceased (mo., day, yr.).....
May 18, 1869

8. AGE: Years..... 77 Months..... Days..... If less than one day.....
hrs..... min.....

9. Birthplace.....
Mc Connellburg, Pa
(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business.....

12. Name..... Charles P. Miles

13. Birthplace..... Maryland

14. Maiden name..... Sarah Johnson

15. Birthplace..... Maryland

16. Informant..... Great E. Miles

Address..... Hill Road, Seat Pleasant

17. Burial..... Date thereof..... 12-23-46

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Reformed Ch. Cemetery

Location..... Boonesboro, Md.

18. Funeral director..... W.W. Chambers Co

Address..... Riversdale, Md

19. (Date rec'd by registrar)..... 12/22/46

19. (Date rec'd by registrar)..... 12/22/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George's

City or town..... Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Hill Road
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 21, 1946, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Acute congestive
heart failure

Due to..... Cardiac vascular
renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

Repetitive medical or surgical procedures?.....

Industrial?.....

M. D. or other?.....

Address..... Freshwater

Date signed 12-27-46



1-35

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

12322

1. PLACE OF DEATH

County Prince George
Village or City Lawrence P.E.D.

1342

Registration Dist. No. 9391

St.

Ward

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.2. FULL NAME Alice Moore

(a) Residence: No.

(Usual place of abode)

If U. S. Veteran, specify WAR

St. Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
----------------------	-------------------------------	---

Se. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day, and year) September 18637. AGE 83 Years Months Days If LESS than
1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. House work10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

(State or country) Mayland13. NAME Upton Moore14. BIRTHPLACE (city or town) Carroll Co.
(State or country) Md15. MAIDEN NAME Emeline Hough16. BIRTHPLACE (city or town) Carroll Co.
(State or country) Md17. INFORMANT Miss Nina Moore
(Address) Montgomery Rd. Laurel Md.18. BURIAL, CREMATION, OR REMOVAL
Place Lawrence Hill Cemetery Date Dec. 9, 194619. UNDERTAKER Ridgely Delby
(Address) 401 W. 2nd St. Laurel Md.20. FILED 12-9, 1946 C. E. Wachter
Registrar Stephens
(Address) Box 5, Prince George St. Laurel Md.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 7, 1946

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from

October 31, 1946, to December 7, 1946I last saw her alive on December 7, 1946; death is said to have occurred on the date stated above, at 9:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Hypertensive Cardi -
Arterial Disease
2 Chronic Nephritis
3 Arterio - sclerosis

Date of onset
19461945
Untreated

Other Contributory Causes of Importance:

Name of operation Date of What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19 Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury Nature of injury 24. Was disease or injury in any way related to occupation of deceased? NoIf so, specify (Signed) Stephens(Address) Box 5, Prince George St. Laurel Md.

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	RECEIVED 1 week ago
Run over by street car	1 week ago

Other contributory causes of importance:

Gastroenteritis	DEC 14 1916
	1-35 1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 133a

CERTIFICATE OF DEATH

Reg. Dist. No. 12323 2310

1. PLACE OF DEATH:

County

City or town

Dro Geo Co.
Cheverly Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Charles Byron Murray

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

6. (b) Name of husband or wife

Mary Alice Murray

6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

Aug 31, 1907

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Printer

11. Industry or business

Star newspaper

MOTHER FATHER

Henry A. Murray

13. Birthplace

Md.

14. Maiden name

Mary J. Thomas

15. Birthplace

Md.

16. Informant

Mary Alice Murray

Address

Hyattsville Md.

17. Burial

Date thereof Dec 18, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington

Location

Washington D.C.

18. Funeral director

L. Gaskins Son

Address

Hyattsville Md.

19. 12/18

1946

(Date rec'd by registrar)

Amanda Deurney

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

2nd

County

Dro Geo Co

City or town

Hyattsville 2nd

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5307

Crittenden St

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 18 1946 1946 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/19 1946 to 12/19 1946

and that I last saw him alive on 12/19 1946

Immediate cause of death Service passing

Due to Pyronephritis bilateral

Duration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George Deurney M. D. or other

Address 3217-38th St. Date signed 12/15/46

RECEIVED

DEC 20 1946

BUREAU

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

12324

CERTIFICATE OF DEATH

Reg. Dist. No. 1420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: **PRINCE GEORGE**
 County **SUITLAND MD.**
 City or town **(If outside city or town limits, write RURAL and give nearest town)**
 How long in above place of death? **34 yrs**
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State **MARYLAND** County **PRINCE GEORGE**
 City or town **SUITLAND** **(If outside city or town limits, write RURAL and give nearest town)**
 Street No. **5070 SILVERHILL ROAD**
 (If rural, give LOCATION) **None**

3. (a) FULL NAME

CLARA LILLIAN GLEASON NORTON

3. (b) Social Security Number

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, married, widowed, or divorced **MARRIED**

6. (b) Name of husband or wife **IRA L. NORTON**

7. Birth date of deceased (mo., day, yr.) **JULY 27th 1888** 8. (c) If alive, give age **years**

8. AGE: **58** Years **0** Months **0** Days **0** If less than one day
 hrs. **0** min. **0**

9. Birthplace **HYATTSVILLE MD**
 (Town, county, and state)

10. Usual occupation **NONE**

11. Industry or business

NONE

12. Name **GILBERT H. GLEASON**

13. Birthplace **BOSTON MASS**

14. Maiden name **LILLIAN E NORTON**

15. Birthplace **CEDARVILLE PA.**

16. Informant **914 Norton**

Address **5070 SILVERHILL RD. SUITLAND MD.**

17. BURIAL Date thereof **12-10-46**
 (Burial, cremation, or removal. Which?) **(month) (day) (year)**

Cemetery or crematory **WASH. NATIONAL**

Location **SUITLAND MD.**

18. Funeral director **W. W. Chambers Co.**

Address **517 11th St. S. E.**

19. Date rec'd by registrar **Dec. 7 1946**

(Date rec'd by registrar) **Carrie F. Campbell**

Registrar **Reg. No. 12747**

MEDICAL CERTIFICATION

20. DATE OF DEATH **Dec 6 1946** at **10:45 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Dec 6 1946** to **Dec 6 1946**

and that I last saw her **alive** on **Dec 6 1946** **1946**

Immediate cause of death **Cerebral Hemorrhage**

DURATION **1946**

Due to **Hypertension**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

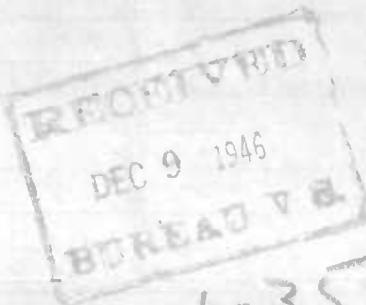
Means of injury Injured at work

23. SIGNATURE **Andrew Sanders**

M. D. or other

Address **4671 Homer Ave.** Date signed **12/7/46**

Notified coroner and approved
Andrew Anderson



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

12325

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County..... Prince George County
City or town..... Oxen Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or instmt address where death occurred:

6000 Brinkley Road

How long in hospital or institution?

3. (a) FULL NAME

DELIA O'BRIEN

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife..... Patrick O'Brien

7. Birth date of deceased (mo., day, yr.) 8.(c) If alive, give age years

1859

8. AGE: Year Month Day If less than one day
87? hrs. min.8. Birthplace..... Ireland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

MOTHER / FATHER	12. Name..... unk
	13. Birthplace

MOTHER	14. Maiden name..... unk.
	15. Birthplace

16. Informant Mr. Charles F. O'Brien (son)

Address 1032 North Nelson, Arlington, Va.

17. Burial Date thereof Dec. 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Rood Cemetery

Location Washington, D. C.

18. Funeral director James T. Ryan, Inc.

Address 317 Pennsylvania Ave., S.E.

19. 12-21-1946 Thos. D. Lafferty
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Prince George

City or town..... Oxen Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. 6000 Brinkley Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1946, at 8:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15 - 1946, to Dec. 21, 1946

and that I last saw her alive on Dec. 21, 1946

Immediate cause of death Acute Peritonitis

Edema

Due to Bronchopneumonia

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

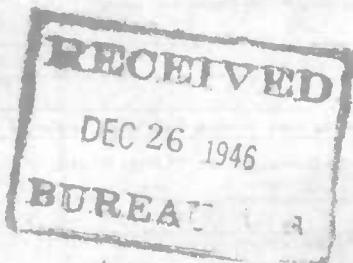
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 2924 Nichols Ave. Date signed 12-21-46



2-2420 ————— 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13B

12326

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County..... Prince Georges County
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 1 month and 25 days
Hospital, Institution, or street address where death occurred:..... Glenn Dale Sanatorium
How long in hospital or institution?..... 1 month and 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town..... Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 309½ Va. Ave. S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

CHARLES. POE.

4. Sex..... Male 5. Color or race..... Colors 6.(a) Single, married, widowed, or divorced..... single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... April 10, 1911

8. AGE:	Years	Months	Days	If less than one day
	35	35	2	10 hrs. min.

9. Birthplace..... Washington, D.C.
(Town, county, and state)

10. Usual occupation..... Labor Foreman

11. Industry or business.....

FATHER 12. Name..... Virgil Poe
13. Birthplace..... North Carolina

MOTHER 14. Maiden name..... Maggie Bailey
15. Birthplace..... Virginia

16. Informant..... Deceased

Address.....

17. Removal (Burial, cremation, or removal. Which?)..... Date thereof..... Dec. 20, 1946
(month) (day) (year)

Cemetery or crematory..... to Washington, D.C.
Location.....

18. Funeral director..... H. Morris & Carter
Address..... 600 2nd St. S.W.

19. Date rec'd by registrar..... Dec. 20, 1946
(Date rec'd by registrar) K. Roland S. Phillips
Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 20, 1946, at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24 in 1946 to Dec. 20 1946 and that I last saw him alive on Dec. 19 in 1946

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION..... 5 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

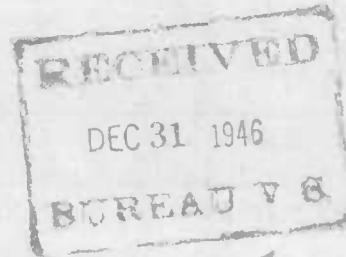
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Peo Pinecone, M.D.

M. D. or other

Address..... Glenn Dale, Md. Date signed..... 12/20/46



2-2430-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

CERTIFICATE OF DEATH

12327

230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reg. Dist. No.

1. PLACE OF DEATH:
 County PRINCE GEORGE
 City or town DANIELS PARK
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
ALICE F. RHINE

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife Richard H. Rhine

7. Birth date of deceased (mo., day, yr.) Dec - 1 9 - 1876

8. AGE: Years 69 Months Days If less than one day
 hrs. min.

9. Birthplace Berwyn md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Horris Ward

MOTHER 13. Birthplace md.

14. Maiden name Mary

15. Birthplace md.

16. Informant Eldred H. Rhine

Address 6915 Linwood Ave. SeaPlumwood

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12 - 16 - 46
 (month) (day) (year)

Location St. John's Episcopal Cemetery

Bethesda - Md.

18. Funeral director Mr. Mr. Chambers Co.

Address 5801 Cleveland Ave. Rivesdale, Md.

19. Date rec'd by registrar Dec 15 1946 Janus Sevey

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGES
 City or town DANIELS PARK
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4910 Street ERIE STREET
 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 1 3 1946, at 8:37 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 5 1946, to Dec 13 1946

and that I last saw her alive on Dec 13 1946

Immediate cause of death Arterio Sclerotic

Heart disease with

Pulmonary edema

DURATION Several years

Due to:

Due to:

Other conditions Hypertrophic

arthritis advanced

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

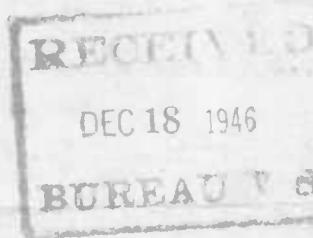
Means of injury _____ Injured at work? _____

23. SIGNATURE Dayton P. Watkins MD

M. D. or other _____

Address 5304 Annapolis Date signed Dec 13 - 46

Roxburyville Md



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

12328

CERTIFICATE OF DEATH

Reg. Dist. No. 2340

1. PLACE OF DEATH:

County. BaltimoreCity or town. Decetech

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Elmer Richards

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

W.

Married

6. (b) Name of husband or wife...

Vermael Richards6. (c) If alive, give age 67 years

7. Birth date of

deceased (me., day, yr.)

Oct 25, 1878

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Former

11. Industry or business

12. Name Joseph Richards13. Birthplace Maryland14. Maiden name Mary Goldsmith15. Birthplace Maryland16. Informant Margaret RichardsAddress 840 Calleek, MD17. Burial Burial Date thereof 12-27-46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. PaulsLocation Baltimore, Md.18. Funeral director Frank DavisAddress 2201 Carrollton, Md.19. 12/26/46 19. 46 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Decetech

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 25 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive ea.....

Immediate cause of death

Congestive heart failure
Due to Cardiac as cause
Renal disease

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Trespassing medical Negligence

23. SIGNATURE

M. D. or other

Address Westville, Md. Date signed 12-28-46

RECEIVED

DEC 28 1946

BUREAU V 8

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1632

12329

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: *Bro Geo Co*
 County: *Hyattsville Md*
 City or town: *(If outside city or town limits, write RURAL and give nearest town)*
 How long in above place of death? *21 years*
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: *Maryland* County: *Bro Geo Co*
 City or town: *(If outside city or town limits, write RURAL and give nearest town)*
 Street No.: *J-308 - 43 Place*
 (If rural, give LOCATION)

3. (a) FULL NAME *Flora H. Riley*
 4. Sex: *Female* 5. Color or race: *white* 6. (a) Single, married, widowed, or divorced: *widowed*
 6. (b) Name of husband or wife: *Filmore Riley*
 7. Birth date of deceased (mo., day, yr.): *July 18 - 1855* 6. (c) If alive, give age: *—* years
 8. AGE:

Years	Months	Days	If less than one day
91	—	—	hrs. min.

 9. Birthplace: *va* (Town, county, and state)
 10. Usual occupation: *housewife*
 11. Industry or business: _____
 MOTHER FATHER
 12. Name: *Filmore Riley*
 13. Birthplace: *west va*
 14. Maiden name: *Mary May*
 15. Birthplace: _____
 16. Informant: *Mrs Mary Langford*
 Address: *College Park Md.*
 17. Burials: *Burials* Date thereof: *Dec 10, 1946* (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or cemetery: *Lorraine*
 Location: *Baltimore Md*
 18. Funeral director: *F. Gasche sons*
 Address: *Hyattsville Md.*
 Date rec'd by registrar: *Dec 10 1946 James Seay*
 Registrar

3. (b) Social Security Number: / / /

MEDICAL CERTIFICATION

2D. DATE OF DEATH: *12-8 1946* at *9:30 A.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Nov. 20 1946 to Dec 8 1946* and that I last saw her alive on *12-8 1946*

Immediate cause of death: *Somnolent*
 Duration: *3 mos.*

Duo to: _____
 Duo to: _____
 Other conditions: _____
 (Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

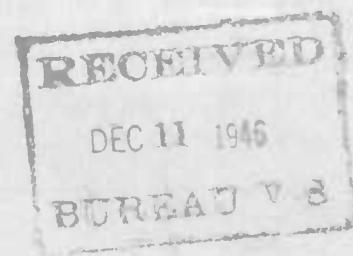
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

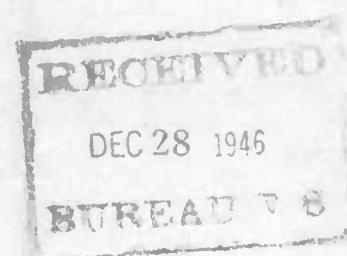
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE: *W. R. R. 12-8-46* M. D. or other: _____
 Address: *West. R. R. 12-8-46* Date signed: *12-8-46*



1-35



2-2450- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12331

CERTIFICATE OF DEATH

12331

Reg. Dist. No. 2450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

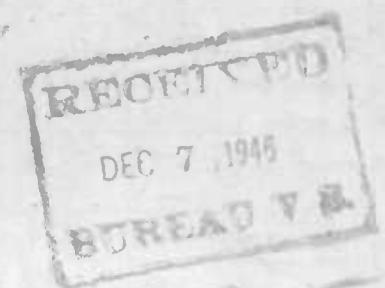
MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
 County..... Prince Georges
 City or town..... Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 17 hrs.
 Hospital, institution, or street address where death occurred:..... Edmonston Road.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md. County..... Prince Georges
 City or town..... Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Edmonston Road.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Gerald Roland Salisbury
 4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced
 Male White Single
 6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... 10/10/46
 8. AGE: Years Months Days If less than one day
 1 24 hre. min.
 9. Birthplace..... Geneva, New York
 (Town, county, and state)
 10. Usual occupation.....
 11. Industry or business
 MOTHER FATHER
 12. Name..... Jessie Otis Salisbury
 13. Birthplace..... W. Va.
 14. Maiden name..... Gladys Rose Wagner
 15. Birthplace..... Baltimore, Md.
 16. Informant..... Mrs. Gladys R. Salisbury
 Address..... Berwyn, Md.
 17. Burial (Burial, cremation, or removal. Which?)..... Date thereof..... Dec 5, 1946
 Cemetery or crematory..... Evergreen Bladensburg Md
 Location.....
 18. Funeral director..... F. Goede Sons
 Address..... Hyattsville Md.
 19. Date rec'd by registrar..... Dec 5 1946 James Seven
 (Date rec'd by registrar) 15. James Seven
 Registrar

3. (b) Social Security Number.....
 MEDICAL CERTIFICATION
 20. DATE OF DEATH..... 12/4/46
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....
 and that I last saw h..... alive on 19.....
 Immediate cause of death..... asphyxia
 DURATION
 Due to..... Overlaying of Mother
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings or operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Accident Date of 12/4/46
 Where did injury occur?..... Berwyn
 (City or town) (County) (State) P.G. Md.
 Injured at home, farm, industry, public place (where?)..... home
 Means of injury..... Overlaying of Mother
 23. SIGNATURE..... Medical Examiner
 M. D. or other
 Address..... Hyattsville Md. Date signed 12/4/46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13.

CERTIFICATE OF DEATH

12332

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 22 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 22 days

3. (a) FULL NAME

CLIFFORD R SCOTT

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Dorothy L. Scott

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1904

6. (c) If alive, give age 42 years

8. AGE: Years Months Days If less than one day

41 11 14 hrs. min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Cab Driver

11. Industry or business

12. Name Harry E. Scott

13. Birthplace Des Moines, Iowa

14. Maiden name Virginia S. Winfree

15. Birthplace Richmond, Virginia

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal? Which?) Date thereof Dec. 8, 1946

(month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location

18. Funeral director Wm. Lee Sons Co

Address 360-4 st. N.E. Wash. D.C.

19. Dec. 8, 1946 Rowlands Philips

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 153 Kentucky Ave., S. E.

(If rural, give LOCATION)

2. (a) If veteran, name war Army, 1921 to 1924

3. (b) Social Security Number

579-14-7845

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 8, 1946, 12th P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15, 1945, to Dec. 8, 1946

and that I last saw him alive on Dec. 8, 1946

Immediate cause of death

Pulmonary tuberculosis

Due to: tubercular laryngitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

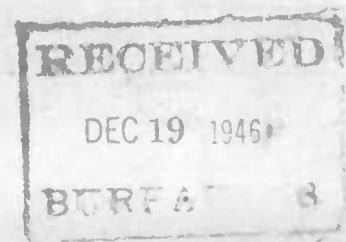
Injured at work?

23. SIGNATURE

Daniel Leo Finegan, M.D.

M. D. or other

Address: Glenn Dale, Md. Date signed: 12/8/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5520

12333

CERTIFICATE OF DEATH

Reg. Dist. No. 2451

1. PLACE OF DEATH:

County

Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William F. Sedwick

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Marie F. Sedwick

7. Birth date of deceased (mo., day, yr.)

Oct 17, 1883

6. (c) If alive, give age years

8. AGE:

Years 63 Months Days hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Plumber

11. Industry or business

Thomas Sedwick

12. Name

Thomas Sedwick

13. Birthplace

Md

14. Maiden name

Mary Hooper

Md

15. Birthplace

Marie F. Sedwick

16. Informant

Riverdale Md

Address

Burial

Date thereof Oct 23, 1941
(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Lincoln

Location

Washington D.C.

18. Funeral director

F. Glascha Son

Address

Hyattsville Md.

19. Dec. 28 1941

At the

ts

M. D. or other

Deceased

RECEIVED

DEC 24 1946

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2 - 2450

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 838

12334

CERTIFICATE OF DEATH

Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

1. PLACE OF DEATH: Prince Georges
County Riverdale
City or town. (If outside city or town limits, write RURAL and give nearest town) 2 Yrs. 3 mos.
How long in above place of death? 2 Yrs. 3 mos.
Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hospital
How long in hospital or institution? 2 Yrs. 3 mos.

3. (a) FULL NAME Mrs. Margaret Virginia Smallwood

4. Sex Female	5. Color or race white	6. (a) Single, married, widowed, or divorced Widowed
---------------	------------------------	--

6. (b) Name of husband or wife Ryder Lee Smallwood

7. Birth date of deceased (mo., day, yr.) August 17, 1866

8. AGE: Years 80	Months 4	Days 8	If less than one day hrs. min.
------------------	----------	--------	--------------------------------

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation. Hswf.

11. Industry or business

FATHER 12. Name John William Messick
13. Birthplace Maryland

MOTHER 14. Maiden name Alice Jane Jenson
15. Birthplace Maryland

16. Informant Hospital Records

Address

17. Burial Date thereof 12-28-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lincoln Cemetery
Location 1000 Cleveland Avenue, Bel Air, Md.

18. Funeral director W. W. Chambers, Cor.

Address 5501 Cleveland Ave, Bel Air, Md.

19. Date 26-1946 M. D. or other
(Date rec'd by registrar) Severe
Means of Injury Injuring local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town. (If outside city or town limits, write RURAL and give nearest town) Mitchellville
Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1946 at 8:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3:30 P.M. to Dec 25 1946 and that I last saw her alive on Dec 25 1946.

Immediate cause of death Cerebral thrombosis DURATION 4 mos.

Due to General arteriosclerosis 10 years
with hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

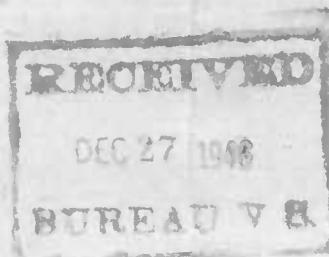
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Malin M.D.

4407 Lawrence Rd. M. D. or other

Address Bel Air, Md. Date signed 12-25-46



1-25-

2-2450 ————— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12335

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County

Prince George

City or town

Arlington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

5701 - Arlington Road

How long in hospital or institution?

3. (a) FULL NAME

Raymond de Long Stockman

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White + married

6. (b) Name of husband or wife

Lucy Stockman

(b) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.)

Sept 13, 1889

8. AGE:

Years Months Days If less than one day

57

3

✓

hrs. min.

9. Birthplace

Washington DC

(Town, county, and state)

10. Usual occupation

Patent Attorney

11. Industry or business

Charles J Stockman

12. Name 13. Birthplace

District of Columbia

14. Maiden name

Mary Corredor

15. Birthplace

District of Columbia

16. Informant

Lucy Stockman

Address 5701 - Arlington Road, D.C. 20004

17. Burial

Date thereof 12/17/96

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington Hall

Location

Arlington, Va.

18. Funeral director

John Chambers Co.

Address 5701 St. L

19. Dec. 16 1946

(Date rec'd by registrar)

Carrie F. Campbell.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1946 at 6:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death

Coronary occlusion

DURATION

Due to Cardiomyopathy

disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy medical examiner

John J. Don

Forestville Md

Date signed 12/15/46

RECEIVED

DEC 18 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

12336

CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly and legibly.

MARGIN RESERVED FOR BINDING

is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Prince Georges

City or town Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos., 25 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 9 mos., 25 days

3. (a) FULL NAME

SUGGS, LILLIE

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Colored Married

6.(b) Name of husband or wife Jack Suggs

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1909 6.(c) If alive, give age 38 years

8. AGE: Years Months Days If less than one day
37 37 11 10 hrs. min.9. Birthplace Wayne County, North Carolina
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER 12. Name Elbert Hunter

13. Birthplace Wayne, North Carolina

14. Maiden name Pennie Gordon

15. Birthplace Wayne, North Carolina

16. Informant Deceased

Address

17. Removal Date thereof 12-18-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory to Wash. DC

Location

18. Funeral director Johnson & Jenkins

Address 2853 3rd Ave

19. 12-18 1946 Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 832 5th Street, N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1946 at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/21 1946 to 12/17 1946

and that I last saw her alive on 12/17 1946

Immediate cause of death

pulmonary tuberculosis

DURATION

37 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Finegan M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 12/17/46



2-25

2-2430-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

CERTIFICATE OF DEATH

12337-2420
Reg. Dist. No.

1. PLACE OF DEATH:

County... *Baltimore*
City or town... *Dupont Heights*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alberta Thomas

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female Colored married*6. (b) Name of husband or wife... *Frank Thomas*

7. Birth date of deceased (mo., day, yr.)

1893 B. (c) If alive, give age 54 years

8. AGE:

Years	Months	Days	If less than one day
53			hrs. min.

8. Birthplace

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

12. Name... *Bonnie Clarke*13. Birthplace *Maryland*

14. Maiden name

15. Birthplace

16. Informant

*Frank Thomas*Address *Dupont Heights Md.*

17. Burial

Date thereof... 1 3 47
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Forrestville

Location

Maryland

18. Funeral director

Arthur S. Rollins

Address

4339-Hunt Pl. N.E.

19. Date rec'd by registrar

Dec. 31 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *Baltimore* June *George*
City or town... *Dupont Heights*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 30 1946 at 6:00 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Oct. 25 1946* to *Dec. 30 1946* and that I last saw her alive on *Dec. 30 1946*

Immediate cause of death

Brain Hemorrhage ?

Due to

Hypertension ?

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. B. Beedon M.D.
M. D. or other
Address *4423-Hunt Pl. N.E.* Date *Dec. 30 1946*

Registrar

RECEIVED

JAN 2 1947

BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

CERTIFICATE OF DEATH

12338

232

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Prince George

City or town

Croom

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

Mt. Calvert Road

How long in hospital or institution?

3. (a) FULL NAME

Vincent Alonzo Tolson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife

Eleanor Tolson

7. Birth date of deceased (mo., day, yr.)

September 18, 1911

8. (c) If alive, give age 33 years

8. AGE:

Years

Months

Days

If less than one day

35

2

20

hrs. min.

9. Birthplace

Upper Marlboro Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name Robert Tolson

13. Birthplace

Maryland

14. Maiden name

Mandie Gordon

15. Birthplace

Maryland

16. Informant

Eleanor Tolson

Address

Croom, Md

17. Burial

Date thereof 12-14-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Croom, Md

18. Funeral director

Pitcher Bros.

Address

Upper Marlboro Md

19. (Date rec'd by registrar)

Dec 13 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Prince George

City or town Croom

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mt Calvert Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1946 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18... to 19...

and that I last saw h... alive on

Immediate cause of death

Acute congestive
heart failure
Due to Acute Cardiac Arrest

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work
Reputed medical opinion

Signature J. S. Tolson M. D. or other

Address

Janesville Md Date signed 12-14-46

RECEIVED

DEC 17 1946

BUREAU F.B.I.

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JAN 13 1947

BUREAU 8

2-25

2-2390- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *12339*

CERTIFICATE OF DEATH

Reg. Dist. No. *245*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County *Prince George*
 City or town *Hyattsville Md*
(If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: *Mother Jones Rest Home*
 Stay in hospital or Inst. (yrs., or mos., or days)
 Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

William Walter Tucker

4. Sex *m.* 5. Color or race *w.* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Mary M. Tucker*

7. Birth date of deceased (m.e., day, yr.) *Aug. 24 1862*

8. AGE: Years *84* Months Days If less than one day hrs. min.

9. Birthplace *Md.*
(Town, county, and state)

10. Usual occupation *Retired*

11. Industry or business

12. Name

13. Birthplace *Md.*

14. Maiden name *Susan F. Tucker*

15. Birthplace *Md.*

16. Informant *James E. Tucker*

Address *2106 Bryant St N.E.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *Dec 13 1946* (month) (day) (year)

Cemetery or crematory *Friendship Md.*

Location

18. Funeral director *W. E. Funeral Home*

Address *4812 - 1/2 acre NW.*

19. (Date rec'd by registrar) *Dec 11 1946* James Sevey
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Washington DC*
 City or town *Washington DC* Ward No.
 Street No. *2106 Bryant St N.E.*
(If outside city or town limits, write RURAL NEAR and give town)
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *12/10 1946* at *48* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *8/1 1946* to *12/10 1946*, and that I last saw *him* alive on *12/18 1946*.

Immediate cause of death *Myocardial failure*

DURATION

1 yrs

Due to *Cardio-renal-vascular disease*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *R. H. Cowley MD*

M. D. or other

Address *3100 - 20 - NE* Date signed *12/10/46*



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

12340

2451

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

3715 Volta Ave

How long in hospital or institution?

3. (a) FULL NAME

Clyde Wilbur Vance

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Rebecca E Vance

7. Birth date of deceased (mo. day, yr.)

Aug. 6, 1909

6. (c) If alive, give age 33 years

8. AGE:

37 years 3 months 28 days

it less than one day

hrs. min.

9. Birthplace

Browns Summit N. C.

(Town, county, and state)

10. Usual occupation

Auto mechanic

11. Industry or business

Tennass See Station

12. Name

Charles W Vance

13. Birthplace

N. C.

14. Maiden name

Alto Pogram

N. C.

15. Birthplace

N. C.

16. Informant

Rebecca E Vance

Address

1332 Newton St NE DC

17. Removal

Date thereof 1/24/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

West. D.C.

Location

Wm. Lewis Co

18. Funeral director

3004 18th N E Wash D.C.

Address

M. A. J. Severe

19. Date rec'd by registrar

19. 4. 6 M. A. J. Severe

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1332 Newton N. E.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

579-01-1476

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 4 1946 at 5¹⁰ PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19.

and that I last saw him alive on

18.

Immediate cause of death

Nervousness and

shock

Due to Gun shot wound

through heart

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 12-4-46Where did injury occur? Brentwood (City or town) P. D. H. (County) D.C. (State)Injured at home, farm, industry, public place (where?) Private houseMeans of injury hurled self out of window ED. IN WORK?Necropsy Medical Examiner23. SIGNATURE James J. Doyle M. D. or otherAddress Brentwood Date signed 12-4-46



2-2450 - 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County..... Prince George's
City or town..... Cheverly

(If outside city or town limits, write RURAL and give nearest town)

19 hrs

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pr. George General Hosp.

19 hrs.

How long in hospital or institution?

3. (a) FULL NAME

Wardlow, Mrs. Mary B

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

7 w

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... May 1 1889

6. (c) If alive, give age..... years

8. AGE: Years..... 57 Months..... Days..... If less than one day
..... hrs. min.

9. Birthplace..... Ga (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Jones Hughes

13. Birthplace..... Ga

14. Maiden name..... Eta McDonald

15. Birthplace..... Ga

16. Informant.....

Address.....

17. Burial (Burial, cremation, or removal, which?)..... Date thereof (month) (day) (year)

Dec 28, 1946

Cemetery or crematory..... Ft. McHenry Cemetery

Location..... Colmar Manor Md.

18. Funeral director..... W. W. Chambers Co.

Address..... 1400 - Charing St. N.W.

19. Day 25 1946 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Pr. George

City or town..... Maywood Gardens

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4200 29 St. apt. T

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 12 - 25 1946 a.m. 7:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Dec 1946 to 25 Dec 1946

and that I last saw her alive on 25 Dec 1946

Immediate cause of death..... Acute myocardial infarction

19.46.

Duration..... 48 Hrs

Due to..... Coronary artery Disease 1+ years

Due to..... arteriosclerosis, generalized 2+ years

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Samuel J. N. Sugar, M.D.

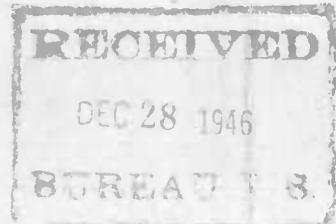
M. D. or other

Address..... 4300 Maywood Drive Date signed..... 25 Dec 46

Mt. Rainier, Md.

12-25-46

Mr. Gayd notified @ 7³/₄ am



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

12342

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH: Prince Georges
 County: Prince Georges
 City or town: Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 5 days
 Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: D. C. County: Washington
 City or town: Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 732 LaMont St., N. W., Apt. 402
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

BESSIE WHITE

3. (b) Social Security Number
579-26-2217

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1912

8. AGE: Years Months Days If less than one day
34 34 10 24 hrs. min.9. Birthplace Orange Co., Virginia
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Daniel White
13. Birthplace Orange Co., Virginia14. Maiden name Clara Cooper
15. Birthplace West Virginia

16. Informant Deceased

Address

17. Removal Date thereof Dec. 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington D. C.
Location18. Funeral director R. J. M. & Son
Address 1820 - 9th St. N.W. Washington, D.C.19. Dec. 21 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1946, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
10/14/1946 to 12/20/1946
and that I last saw her alive on 12/20/1946Immediate cause of death
Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 12/20/46



2-2430- 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12343

CERTIFICATE OF DEATH

Reg. Dist. No. 2342

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

HATTIE E. WHITE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife

Benj. E. White

7. Birth date of deceased (mo., day, yr.)

June 30 - 1877

6. (c) If alive, give age years

8. AGE:

69 Years Months Days If less than one day
hrs. min.

9. Birthplace

Forestville, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Christopher Moore

MOTHER

FATHER

12. Name

Christopher Moore

13. Birthplace

M. D.

14. Maiden name

Mary Elizabeth Burgess

15. Birthplace

M. D.

16. Informant

Audrey B. White

Address

Forestville, Maryland

17. Burial

Burial Date thereof Dec 13-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Christ Church Cemetery

Location

Clinton, Maryland

18. Funeral director

Thomas F. Murray Home

Address

2507 - Nichols Ave

Dec 11

1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George Co.

City or town Clinton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1946 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 4 1946 to Dec 11 1946

and that I last saw her alive on Dec 10 1946

Immediate cause of death Acute cardiac

decompensation

DURATION

1 day

Due to General arteriosclerosis

and a. with coronary thrombosis

Due to a. attack of angina

unknown

3 mo.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

no

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

1. Where did injury occur (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury

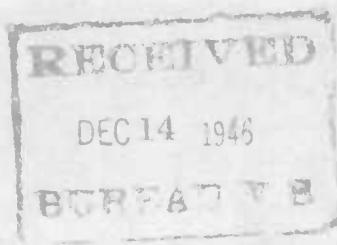
Injured at work

23. SIGNATURE

M. D. *audrey van yatta*

Address 3440 Silver Hill Rd Date signed Dec 11 1946

Washington 19th



1-25

2-2340-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 734

CERTIFICATE OF DEATH

Reg. Dist. No.

12344
231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Jeanne May Whitney

9. (c) If alive, give age years

April 20 - 1871

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years Months Days If less than one day

75

hrs. min.

9. Birthplace

Concord, N. Hampshire

10. Usual occupation

Florist

11. Industry or business

Geo. L. Whitney

12. Name

Geo. L. Whitney

13. Birthplace

Caroline, N. Hampshire

14. Maiden name

Caroline L. Gaze

15. Birthplace

N. Hampshire

16. Informant

Mrs. T. Head (a. Williams, b. b.)

Address

317 Pine Grove Drive S.E. Gaithersburg

17. Burial, cremation, or removal. Which?

Burial transportation Date thereof 12/20/46

(month) (day) (year)

Cemetery or crematory

Geo. Washington County Cemetery

Location

Ridge Wood, Md.

18. Funeral director

Dr. Chambers Co.

Address

501 Cleveland Ave., Riverdale, Md.

19. Date rec'd by registrar

19/12/46

(Date rec'd by registrar)

Amanda Dauney

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Md.

County

Geo. Co.

City or town

317 Pine Grove Dr., Morningside Village

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Morningside Village

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 23, 1946, at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 20 1946, to December 23 1946

and that I last saw him alive on December 23 1946

Immediate cause of death

Hypostatic pneumonia

Due to

Brown atrophy heart

Due to

Multiple thrombophlebitis

sludging & perirectal veins

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE William Brannin

M. D. Doctor

Address Capitol Notes Rd Date signed 12/23/46

RECEIVED

DEC 30 1946

BUREAU F B I

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

CERTIFICATE OF DEATH

12345

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County, Orience Geo. - Harp
City or town, Orience, Geo. - Harp, Cheshire, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Orience Geo. - Harp, Cheshire, Md.

How long in hospital or institution?

3. (a) FULL NAME

Maddie T. Wilcombe4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.6. (b) Name of husband or wife, Calvin Wilcombe7. Birth date of deceased (mo., day, yr.) Nov. 10 - 1882 6. (c) If alive, give age years8. AGE: Years 64 Months Days If less than one day hrs. min. 9. Birthplace England (Town, county, and state)10. Usual occupation Housewife11. Industry or business Geo. - Baker12. Name Geo. - Baker13. Birthplace England14. Maiden name Hannah15. Birthplace England16. Informant Calvin WilcombeAddress 457 Lucy Fellow Hyattsville, Md.17. (Burial, cremation, or removal, which) Cremation Date thereof 12-20-46

(month) (day) (year)

Cemetery or crematory St. Luke's CemeteryLocation Wash. D. C.18. Funeral director W. W. Chambers Co.Address Orience Geo. - Harp19. (Date rec'd by registrar) 12/20 1946(Date rec'd by registrar) Amanda DorneyRegistrar 12/20 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County OrienceCity or town (If outside city or town limits, write RURAL and give nearest town)Street No. 457 1/1 Lucy Fellow Hyattsville(If rural, give LOCATION) England

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 t₉ 46 at 11⁰⁰ M₁₅21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 46 t₉ 46 to 12-20 1946, and that I last saw her alive on 12-20 1946.

Immediate cause of death

Carcinoma of lung DURATION 1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Jean and Harry

M. D. or other

Address Hyattsville, Md. Date signed 12-20-46

RECEIVED

DEC 23 1946

BUREAU V. G.

1-51-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

12346

CERTIFICATE OF DEATH

Reg. Dist. No. 2420

1. PLACE OF DEATH:

Prince George County
 City or town 6916 Lenwood Ave, Seat Pleasant, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

WILLIAM MOSES WILLIAMS

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

HATTIE MAE BIGGS WILLIAMS

63 years

6. (c) If alive, give age

7. Birth date of deceased (mo. day. yr.)

SEPT 14, 1876

8. AGE:

Years

Months

Days

If less than one day

70

2

15

.hrs. .min.

9. Birthplace

Wales

(Town, county, and state)

10. Usual occupation

MECHANIC

11. Industry or business

AIR PLANE DEPOT

12. Name

UNKNOWN

13. Birthplace

WALES

14. Maiden name

UNKNOWN

15. Birthplace

WALES

16. Informant

Mr HOWARD M WILLIAMS

Address

6916 Lenwood Ave, Seat Pleasant Md.

17. Removal

Date thereof Aug 1, 1941

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location

Glen, New York

18. Funeral director

J. Arthur Walters

Address

254 Carroll St. Takoma Park, D.C.

19. Date rec'd by registrar

1946

(Date rec'd by registrar)

Carrie F. Campbell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 1, 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 9, 1946, to Dec 1, 1946

and that I last saw him alive on Nov 29, 1946

Immediate cause of death

Paroxysm of the stomach unknown

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Esophageal carcinoma found at Wash. San Date of op. Aug 4, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

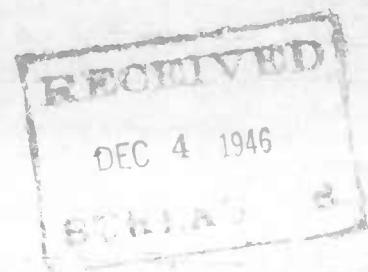
Injured at work?

23. SIGNATURE

George G. Stoddard, M.D.

M. D. or other

Address 1450 14th St. Date signed Dec 1, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

12347

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County..... Prince George
City or town..... Cheverley

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital institution, or street address where death occurred:

Prince George General Hospital

How long in hospital or institution? 4 days

3. (a) FULL NAME

Andrew J. Wray

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 1946 1889

6. (c) If alive, give age..... years

8. AGE: Years 57? Months Days If less than one day hrs. min.

9. Birthplace..... (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... George Wray

13. Birthplace.....

14. Maiden name..... Tennessee

15. Birthplace.....

16. Informant..... Mrs. William Burchart

Address..... 5637 Annapolis Road, Bladensburg

17. Removal (Burial, cremation, or removal. Which?)

Date thereof..... Dec 11, 1946

(month) (day) (year)

Cemetery or crematory..... Rockwood Va.

Location..... Va.

18. Funeral director..... P. A. Tolson

Address..... 3619-14 2d St. N.W.

19. (Data reg'd by registrar) 12/11 1946 Amanda Dourley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County..... Prince George

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

5637 Annapolis Road, Bladensburg, Md.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11 December 1946 at 9^{1/2} M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 Dec. 1946, to 11 Dec. 1946

and that I last saw h. in alive on 11th December 1946

Immediate cause of death.....

Intestinal Obstruction
Myocarditis, bronchitis
Diarrhoea + Tolson

Due to.....

Other conditions..... Aden Carcinoma of Clark

esophagus

(Include pregnancy within 3 months of death)

Major findings of operations..... Necrotic intestinal

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... William Melton

M. D. or other

Address..... 1801 Eye St. N.W. Date signed..... 11 Dec. 46

